

**H.R. _____, “RESTORING ACCOUNT-
ABILITY IN THE INDIAN HEALTH
SERVICE ACT OF 2023”**

LEGISLATIVE HEARING

BEFORE THE

SUBCOMMITTEE ON INDIAN AND INSULAR AFFAIRS

OF THE

COMMITTEE ON NATURAL RESOURCES

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

Thursday, July 27, 2023

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**LEGISLATIVE HEARING ON H.R. ____, TO
AMEND THE INDIAN HEALTH CARE
IMPROVEMENT ACT TO IMPROVE THE RE-
CRUITMENT AND RETENTION OF EMPLOY-
EES IN THE INDIAN HEALTH SERVICE,
RESTORE ACCOUNTABILITY IN THE INDIAN
HEALTH SERVICE, IMPROVE HEALTH SERV-
ICES, AND FOR OTHER PURPOSES,
“RESTORING ACCOUNTABILITY IN THE
INDIAN HEALTH SERVICE ACT OF 2023”**

**Thursday, July 27, 2023
U.S. House of Representatives
Subcommittee on Indian and Insular Affairs
Committee on Natural Resources
Washington, DC**

The Subcommittee met, pursuant to notice, at 2:22 p.m., in Room 1334, Longworth House Office Building, Hon. Harriet Hageman [Chairwoman of the Subcommittee] presiding.

Present: Representatives Hageman, Carl; and Leger Fernández.
Also present: Representative Johnson.

Ms. HAGEMAN. The Subcommittee on Indian and Insular Affairs will come to order. Without objection, the Chair is authorized to declare recess of the Subcommittee at any time. In fact, that may be necessary as we have one more vote series today, but we might be able to get through all the testimony, we will just see how the schedule goes.

The Subcommittee is meeting today to hear testimony on a Discussion Draft of the “Restoring Accountability in the Indian Health Service Act of 2023.” Under Committee Rule 4(f), any oral opening statements at hearings are limited to the Chairman and the Ranking Minority Member. I therefore ask unanimous consent that all other Member’s opening statements be made part of the hearing record if they are submitted in accordance with Committee Rule 3(o).

Without objection, so ordered.

I ask unanimous consent that the gentleman from South Dakota, Mr. Johnson, be allowed to sit and participate in today’s hearing.

Without objection, so ordered.

I will now recognize myself for an opening statement.

**STATEMENT OF THE HON. HARRIET M. HAGEMAN, A REP-
RESENTATIVE IN CONGRESS FROM THE STATE
OF WYOMING**

Ms. HAGEMAN. Today, the Subcommittee is meeting to consider a discussion draft of the “Restoring Accountability in the Indian Health Service Act of 2023.” This legislation aims to provide tools

so the agency can recruit and retain the very best people. The bill would do this by aligning IHS's pay system with the Veterans Administration's, providing better and slightly expanded benefits for healthcare workers, direct higher authority, improving data collection on patient care, among other reforms.

The legislation would streamline processes to get rid of unqualified and even predatory staff in an efficient way that protects patients and improves care. The bill would also confirm whistleblower protections that protect those who bring issues to the attention of the IHS, the Department of Health and Human Services, and Congress. The bill also includes several required reports on the reforms that would be instituted to make sure they work as Congress intended.

It is a goal of this hearing to discuss what provisions of this draft bill are still needed and what changes and other improvements to IHS can be included. The IHS has long been plagued with issues of substandard medical care, high staff vacancy rates, aging facilities and equipment, and unqualified or predatory healthcare staff. Many of these issues first came to national attention in 2010 when the Senate Committee on Indian Affairs held a hearing and completed subsequent investigation on the issues surrounding IHS of the Great Plains area, showing in detail the extreme deficiencies across IHS Direct Service Health Units.

The agency has self-identified that its inability to attract and retain quality employees has a domino effect on the quality of care they provide. It is disheartening and frustrating to think about how long these issues have continued. In 2015, further issues came to light in the Great Plains area resulting in the termination of CMS contracts, the closure of an emergency department, and the deaths of nine patients. And in Fiscal Year 2021, the Portland area reported 100 percent of their dentist positions were vacant.

Vacancies are not the only issue. Issues of hiring sub-par candidates, lengthy hiring timelines, and lower-tier benefits have also factored into the issues of staffing IHS facilities. One doctor was hired at an IHS facility in the Southwest without consideration of all medical licenses, ignoring disciplinary marks she had received in other states. Another doctor who was unable to find work in other Southwest area hospitals was hired at IHS after five malpractice settlements in 5 years.

These are just two grievous examples that highlight the policy changes that need to be made. While IHS does have authority to improve some of these issues on its own, statutory efforts is the most certain way to provide stronger guidelines and require oversight. This draft legislation works toward this goal and has the two-pronged approach of also including more incentives for medical professionals to come work at IHS for the betterment of the served communities. We must do better for our American Indians and Alaska Natives. This conversation and this discussion draft is a start.

We have now had several hearings dealing with the IHS and our ability or inability to provide adequate medical and dental services to our Native people in the United States. We have had several women who have come to testify and provided extensive information and detail about what they have encountered for their tribal

members, and it is just simply unacceptable. We need to fix this, and I am hoping that this is an excellent step in that direction. There are many aspects of the IHS and Native healthcare that can be improved, and I hope this hearing pushes those conversations forward.

I want to thank all of our witnesses for appearing before the Subcommittee today, and I look forward to a robust discussion on this important issue.

The Chair now recognizes the Ranking Minority Member for any statement.

STATEMENT OF THE HON. TERESA LEGER FERNÁNDEZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Ms. LEGER FERNÁNDEZ. Thank you, Madam Chairwoman, and thank you, witnesses, for coming and sharing with us your expertise, for sharing with us your written testimony.

The Indian Health Service and the work they do on behalf of American Indians and Alaska Natives is critical. What they do, and sometimes what they fail to do, is a matter of life and death, and we need to remember that the life expectancy for American Indians and Alaska Natives is just 65 years old. That is 10 years lower than the national average. That is unacceptable. Congress and IHS simply have to do better.

So, the draft discussion, which is great because we can have a discussion about it, the “Restoring Accountability in the Indian Health Service Act” is a good starting point. I do appreciate the sponsors and this Committee’s focus on the IHS and the bill’s intent to address many of the issues that the IHS faces.

As an example, recruiting and retaining medical providers remains a serious challenge for the IHS, given the rural communities they serve. With that in mind, the draft bill would provide tenant-based rental assistance to an employee of the service who agrees to serve for not less than 1 year. It also expands the IHS loan repayment eligibility to attract more professionals. Things I hear about all the time, both of those, housing and let’s get some professionals from here and get them back and recruit them.

The draft bill would also require HHS to update its 2006 Tribal Consultation Policy every 5 years and establish a demonstration project where IHS may provide service units with additional resources. They are meaningful provisions. They have the potential to translate into better service and care outcomes.

However, we know our witnesses here are going to tell us, I have read it in your written testimony, that Congress has grossly underfunded the Indian Health Service compared to its current need. Historic underfunding contributes directly to shortages and adequate healthcare for tribal patients, resulting in gaps in treatment or referrals to outside facilities, which could be impossible for some tribal members who are living in rural communities.

In fact, the 2018 U.S. Broken Promises Report noted the annual budget request for IHS meets just over half of the needs. As one example of this underfunding, IHS hospitals are overcrowded and falling apart. They have an average age of around 40 years compared to about 10 in the private sector. I have seen these hospitals;

I have seen the leaky roofs. The Gallup Indian Medical Center has been on the priority list for way too long. It is clear that the Federal Government has not delivered on its trust and treaty promises to Indian Country.

Despite the additional IHS programs and requirements in this draft bill, it doesn't authorize any additional appropriations to accomplish the goals it sets out. And I appreciate the funding inquiries for IHS and the current House Interior Environment Appropriations bill. But that is still \$2.2 billion less than what the Administration requested.

Our witness from the National Indian Health Board also highlights in his testimony that funding for IHS this year should be roughly \$50 billion. In other words, the current proposed funding is seven times less than what is needed. If Congress continues to underfund the Service, we won't make the progress we need to.

So, I thank you, Madam Chair, for hearing this bill. I hope you will also be willing to work together so we can support additional funding for IHS to address the concerns of this bill and to meet the expectations. This draft, however, does help IHS in offering critical, culturally-competent, culturally-competent, that is so key, healthcare services through its provisions to improve hiring and retention, to require cultural training for certain employees, and encourage greater transparency and dialogue between the tribes and the IHS. Improving IHS care with appropriate funding, creative authorities, and accountability is important work that our Committee should and is addressing today.

I am committed to working with the tribes, the IHS, and the Majority to do just that. As part of this work, it is key that we hear directly from tribes across the country and with direct service providers and 638 contracts and compacts. Indian Country deserves better care. Let's get it to them.

With that, I yield back.

Ms. HAGEMAN. Thank you. The Chair now recognizes Mr. Johnson for 5 minutes to speak on his legislation.

STATEMENT OF THE HON. DUSTY JOHNSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH DAKOTA

Mr. JOHNSON. Thank you, Madam Chair and Madam Ranking Member.

When I am traveling in Indian Country in South Dakota, of course you hear a lot of concerns, lots of tribal members will note areas for improvement. We will talk about transportation, we will talk about law enforcement, we will talk about economic development. But no topic comes up more often than IHS. And these can, as our witnesses know, be very emotional conversations because we are dealing with some of the most important issues that people deal with in their lives, the health of themselves and their family members.

And this is a progress that Members of Congress have cared about this a long time. These concepts were originally introduced by Senators Barrasso and Thune and then Congresswoman Noem way back in the 115th Congress. But we continue to talk to experts because we realize that the healthcare that is being provided is not meeting our needs, the needs of tribal members.

There are a lot of reasons for that, but I think we know that we are involved in a staffing crisis in the IHS system. Many of the providers are excellent providers. You can see and feel their compassion. But we also know that there are some providers that are not competent and that there are not enough providers in general.

Now you don't need to take my word for it, Madam Chair. A staffing analysis from a few years ago, I think 2018, said that there was a 25 percent vacancy rate for providers within IHS. And anecdotally, those people who work for IHS are telling me that it has gotten considerably worse since 2018.

Now those deficiencies in staffing, they do manifest themselves in poorer outcomes. The Ranking Member mentioned the alarming life expectancy numbers in Indian Country, and we see that in South Dakota. The life expectancy of a Native American in South Dakota is almost 20 years lower than for a white person in South Dakota. There are a lot of reasons for that, but IHS staffing concerns are clearly an important part of that.

And they also manifest themselves sometimes in really terrible headlines. The Chairman mentioned some of them. In 2015, when the Pine Ridge Emergency Room closed, and it wasn't because of a lack of activity, this was an emergency room that was and is needed there in Indian Country. It took until 2019 before there was a final report about what caused that closure. It was staffing problems, it was inconsistent leadership, and it was a lack of vision from IHS. Again, not my words, those are the findings of the report. And then we have also had truly unfortunate headlines where bad people are allowed to be providers in the system, and in some instances, have systematically abused people that they are to be caring for.

So, this is just a discussion draft. We know that this is not a perfect format. That is why I am so grateful for our witnesses because they are going to help us make this better.

But I think what we have here is a great start, an opportunity to address things like credentialing, like hiring practices, like accountability, like how do we coordinate and get better information from the state medical boards so that we know that these providers have not gotten in trouble somewhere else.

Madam Chair, thanks for this opportunity. I am just so grateful for us to work together to improve healthcare in Indian Country.

Ms. HAGEMAN. Thank you. The gentleman yields back. I will now introduce our witnesses for our panel. Ms. Cindy Marchand, Secretary, Tribal Counsel, Confederated Tribes of the Colville Reservation; Mr. Lee Spoonhunter, the Rocky Mountain Area Representative of the National Indian Health Board, and I am very pleased to say a member of the Northern Arapaho Tribe in the State of Wyoming; Ms. Jerilyn Church, Executive Director, Great Plains Tribal Leaders Health Board. Welcome. We are excited to have you, and we appreciate your willingness to work with us on this incredibly important legislation.

Let me remind the witnesses that under Committee Rules, they must limit their oral statements to 5 minutes, but their entire statement will appear in the record. To begin your testimony, please press the talk button on the microphone. We use timing lights. When you begin, the light will turn green. When you have

1 minute left, the light will turn yellow. At the end of the 5 minutes, the light will turn red and I will ask you to please complete your statement. I will also allow all witnesses on the panel to testify before we begin our Member questioning.

The Chair now recognizes Ms. Cindy Marchand for 5 minutes.

STATEMENT OF CYNTHIA MARCHAND, SECRETARY, TRIBAL COUNCIL, CONFEDERATED TRIBES OF THE COLVILLE RESERVATION, NESPELEM, WASHINGTON

Ms. MARCHAND. Thank you, Madam Chairwoman. Good afternoon, Chairwoman Hageman, Ranking Member Leger Fernández, and members of the Committee. My name is Cindy Marchand, and I am the Secretary of the Colville Business Council, the governing body of the Colville Tribes. Thank you for inviting me to testify on the “Restoring Accountability in the Indian Health Service Act.”

The Colville Tribes is a direct service tribe which means that healthcare and associated billing and administrative support is provided by Federal IHS employees. We are in the beginning stages of contracting all IHS functions under the Indian Self Determination Act, but this process will take time. In the meantime, we have to rely on IHS.

My tribe has endured multiple problems with the IHS’s delivery of healthcare to our citizens during the past few years. We support the Restoring Accountability in the IHS Act and believe that its reforms are long overdue. Like other rural communities recruiting and retaining health providers on the Colville Reservation is challenging. There is a 55 percent vacancy rate at the Colville Service Unit, which is nearly twice the IHS-wide vacancy rate of 28 percent. We currently have 46 vacancies out of a total of staff of 84, and many of the vacant positions have been unfilled for years.

IHS’s hiring and credentialing processes are extremely slow. When a doctor or other healthcare provider applies for a vacant position at the Colville Service Unit, they will often accept a position elsewhere because they simply cannot wait for IHS to complete its background and credential review processes, which usually take months.

The recruitment and retention provisions in Title I of the Act would help address some of these issues. Section 101 would provide parity in the pay schedules for health providers at IHS with those at the Veterans Health Administration and would also expedite credentialing. The Colville Tribe supports these reforms.

As the Committee is aware, Purchased/Referred Care, or PRC, is a program where IHS beneficiaries receive care from private non-IHS health providers when IHS is unable to provide the care in its own facilities. For the 3-year period the IHS Portland area office administered the PRC program at the Colville Service Unit, during this time the PRC program was administered so poorly that we can trace it to deaths in our community.

IHS required on an annual basis our members to produce utility bills, certificates of Indian blood, and other proof of tribal enrollment, and other information not required by the IHS regulations or the IHS handbook to get PRC referrals. Those who were unable to produce this information either went without care or obtained care on their own and subsequently faced third-party collection

agencies when IHS refused to pay for the services. To our knowledge, none of the IHS staff at the Portland area office who imposed these obstacles to eligibility have ever been held accountable.

Two years ago, one of our tribal elders tried repeatedly to obtain a referral for ongoing heart issues and was unable to get calls from IHS returned or otherwise secure a purchase order for the referral by the IHS staff responsible for processing them. The tribal elder died of a heart attack before securing that referral.

There have been many stories like this in our tribal communities, and me and my colleagues on the Colville Business Council field these calls from our constituents regularly. If a referral for PRC is secured, there is no way to predict if IHS will pay the provider in a timely manner, if at all. When IHS does not pay PRC providers, the providers send medical bills to IHS beneficiaries directly.

Section 222 of the Indian Health Care Improvement Act explicitly states that an IHS beneficiary should under no circumstances be liable for payment for authorized PRC services. IHS has never effectively implemented this provision, and providers send the bills IHS does not pay to IHS beneficiaries anyway. We have provided the Committee with language to strengthen Section 222 and address these issues that we would like to see included in Title I of the Act.

In conclusion, the Colville Tribe supports the bill and would like to work with the Committee to ensure that the final bill includes provisions to improve the PRC program for the Colville Tribes and other direct service tribes. I would be happy to answer any questions that the Committee may have. Thank you.

[The prepared statement of Ms. Marchand follows:]

PREPARED STATEMENT OF THE HONORABLE CINDY MARCHAND, SECRETARY,
CONFEDERATED TRIBES OF THE COLVILLE RESERVATION

As a rural, land-based Indian tribe, the Confederated Tribes of the Colville Reservation (“Colville Tribes” or the “CCT”) has unique challenges to providing health care for our tribal community. The CCT is a direct service tribe, which means that health care and associated billing and administrative support is provided by Indian Health Service (“IHS”) employees. The CCT is in the beginning stages of contracting all IHS functions, but this process will take time. In the meantime, we have to rely on IHS to provide quality health care to our tribal citizens.

The Confederated Tribes of the Colville Reservation is a confederation of twelve aboriginal tribes from across eastern Washington state, northeastern Oregon, Idaho, and British Columbia. The twelve constituent tribes historically occupied a geographic area ranging from the Wallowa Valley in northeast Oregon, west to the crest of the Cascade Mountains in central Washington State, and north to the headwaters of the Okanogan and Columbia Rivers in south-central and southeast British Columbia. Before contact, the traditional territories of the constituent tribes covered approximately 39 million acres.

The present-day Colville Reservation is in north-central Washington state and was established by Executive Order in 1872. The Colville Reservation covers more than 1.4 million acres, and its boundaries include portions of both Okanogan and Ferry counties, two of the lowest median income counties in the state. Geographically, the Colville Reservation is larger than the state of Delaware and is the largest Indian reservation in the Pacific Northwest. The Colville Tribes has just under 9,300 enrolled members, about half of whom live on the Colville Reservation.

The CCT appreciates the Committee holding today’s hearing on the “Restoring Accountability in the Indian Health Service Act of 2023” (the “Act”). The CCT worked extensively with the committees of jurisdiction when the bill was first being developed in 2015. Much of the bill focuses on IHS issues that are most relevant to direct service tribes. As a direct service tribe that has endured multiple problems

with the IHS's delivery of health care to our citizens during the past few years, the Colville Tribes supports the Act and believes that its reforms are long overdue.

A. Recruitment and Retention

Like other rural communities, recruiting and retaining health providers on the Colville Reservation is challenging. There is a 55 percent vacancy rate at the Colville IHS Service Unit, which is nearly *twice* the IHS-wide vacancy rate of 28 percent that IHS Director Roslyn Tso reported during her May 11, 2023, testimony before this Committee. Currently, there is a single, part-time dentist at the Colville Service Unit and many of the vacant positions have been unfilled for years.

Health providers in our area have expressed interest in providing health care services on the Colville Reservation but have indicated they would only do so if they contracted directly with the Colville Tribes and bypass having to work through IHS. Providers have indicated to us that the protracted administrative processes and problems locally with IHS's administration of the Purchased/Referred Care ("PRC") program are the primary reasons for their interest working with the CCT directly. When a doctor or other health provider applies for a vacant position at the Colville Service Unit, they will often accept a position elsewhere because they simply cannot wait for IHS to complete its background and credential review processes, which often takes months.

Every health provider vacancy at an IHS service unit creates a domino effect that negatively impacts tribes and tribal citizens. First, a provider vacancy means longer waits by IHS beneficiaries for health care. Other providers must also absorb the patient load, which often leads to providers burning out and looking for employment elsewhere.

Worse, without enough providers, the user population for a given IHS Service Unit has decreased, which ultimately reduces the Service Unit's allocation of PRC funds under the PRC distribution formula. IHS's Portland Area (which includes tribes in Washington, Oregon, and Idaho) does not have and has never had an IHS or tribally operated hospital. Without hospitals that can internalize costs, tribes in the Portland Area are particularly reliant on PRC funds to refer patients to private providers for specialty care that their facilities cannot accommodate. For a direct service tribe, a single health provider vacancy leads to multiple negative outcomes. The Colville Service Unit currently has 46 vacancies out of a total staff of 84.

The recruitment and retention provisions in Title I of the Act would help address some of these issues. Section 101 would provide parity in the pay schedules for health providers at IHS with those at the Veteran's Health Administration and would also authorize housing assistance. The CCT supports these provisions and recommends that Section 101 also add a provision that allows for incentives for service unit CEOs or other senior management positions at the service unit level. IHS recently advertised the CEO position at the Colville Service Unit and, in the Tribes' view, the pay grade was initially too low to attract the type of applicant to a rural area with the experience and qualifications necessary to implement reforms in our Service Unit.

B. Staffing Demonstration Program

The CCT is particularly supportive of Section 108 of the Act, the "Staffing Demonstration Program." The CCT developed this provision in response to its challenges to update its staffing ratios, which have not changed for nearly one hundred years.

The Colville Tribes has previously testified before this Committee regarding the unique challenges that direct service tribes face in updating their staffing levels. For the CCT and similarly situated direct service tribes, these staffing ratios are determined when their initial IHS health facility opens for operation. There are two ways for direct service tribes to update their staffing levels. One is to construct a new facility with IHS funds under the Facility Construction Priority List ("Priority List"), and the other is to build a facility using tribal funds under the Joint Venture program. The Priority List has been closed since 1992 and remaining projects will cost an estimated \$6 billion to complete. Applications for Joint Venture projects are rarely offered, highly competitive, and at the expense of the tribes.

Tribes that have not been able to update their staffing ratios by constructing a new facility under the Priority List or the Joint Venture facility construction programs are frozen in time for staffing ratio purposes. For the CCT, these historic staffing ratios date back to 1927 when the U.S. Public Health Service converted a Department of War building in Nespelem, Washington, for use as the CCT's initial health clinic.

The Colville Tribes was fortunate to have been awarded a Joint Venture facility construction project in 2020 and hopes to update its staffing levels soon. Many other

direct service tribes, however, continue to face challenges associated with historically low staffing levels. The Staffing Demonstration Program would allow the IHS to provide federally managed service units with staffing resources on a temporary basis with the expectation that third party revenue generated by the staff would allow them to be permanent. There is currently no other IHS program that allows this.

C. The Act Should Address IHS's Administration of the PRC Program

As noted above, the PRC program is critical for the Colville Tribes and other Indian tribes in the Portland Area because of the lack of inpatient hospital facilities. Based on the Colville Tribes' experiences in recent years, more congressional oversight of IHS's administration of the PRC program is not only warranted, but necessary, as the PRC program for direct service tribes is literally a matter of life and death.

For an approximately three-year period that ended in October 2022, the Portland Area IHS Office administered the PRC program for the Colville Service Unit in Portland using Portland Area Office staff, not local IHS employees located on-reservation. This led to catastrophic results, including deaths. The severity of these issues prompted the House Committee on Appropriations to direct IHS to brief the Committee on its efforts to improve care at the Colville Service Unit in its report accompanying the FY 2024 Interior spending bill, which the Committee approved last week.

Once the Portland Area Office began administering the PRC program, IHS began imposing onerous documentation requirements not required by the IHS handbook or any other IHS authority on Colville tribal members to prove they were eligible for PRC funds. This meant that tribal elders and other IHS beneficiaries, on an annual basis, had to produce utility bills, certificates of Indian blood and other proof of tribal enrollment, and other information not required by the IHS regulations or the IHS handbook in order to get referrals for specialty care. Those who were unable to produce this information either went without care or obtained care on their own and subsequently faced third party collection agencies when IHS refused to pay for the services.

The Portland IHS Area Director informed the CCT in late 2022 that the additional eligibility requirements should never have been implemented. The damage had already been done, however, and there has never been accountability for those Portland Area IHS personnel that ordered the eligibility requirements implemented at the Colville Service Unit.

In addition to eligibility roadblocks, the communication and beneficiary customer service that IHS provides at the Colville Service Unit has been woeful. Two years ago, a Colville tribal elder tried repeatedly to obtain a referral for ongoing heart issues, complaining to CCT elected officials that he was unable to get calls from IHS returned or otherwise secure a purchase order for the referral by IHS staff responsible for processing them. The tribal elder died of a heart attack before securing the referral. Tragically, there have been many stories like this in the Colville Tribes' tribal community.

For those CCT members who can get referrals and receive specialty care through the PRC program, there is no way to predict if IHS will pay the provider. When IHS does not pay PRC providers in a timely manner, the providers will begin sending the medical bills to IHS beneficiaries directly.

Section 222 of the Indian Health Care Improvement Act (IHCIA) explicitly states that an IHS beneficiary should under no circumstances be liable for payment for authorized PRC services. IHS has never effectively implemented this provision, however, and providers send the bills that IHS does not pay to IHS beneficiaries anyway, which are often later referred to third party collection agencies. This has happened to scores of Colville tribal members in recent years, including CCT elected officials. The CCT is aware of instances where PRC providers have refused to make appointments with IHS beneficiaries—even those with chronic conditions—where the beneficiary has an outstanding balance to the provider that IHS has not paid and the provider has billed to the beneficiary directly.

When faced with notices from collection agencies, the few fortunate IHS beneficiaries who can afford to, will pay the bills out-of-pocket to avoid damage to their credit scores—again, notwithstanding Section 222 of the IHCIA. The IHS has no beneficiary-accessible mechanism for reimbursing IHS beneficiaries in these situations. For the vast majority of IHS beneficiaries that cannot afford to pay the bills that IHS does not pay themselves, they must live with impaired credit scores, higher interest rates, or the inability to obtain credit altogether.

As the Committee and some in Indian Country are aware, in recent years IHS has amassed hundreds of millions in unobligated PRC carryover funds and billions

more in carryover funds from other IHS accounts. Despite this carryover, IHS administers the PRC program like rationed healthcare. The fact that IHS has significant PRC carryover funds and Colville tribal members and others in Indian Country struggle to obtain referrals for PRC care is unconscionable. Even worse, when PRC providers do not get paid by IHS in a timely manner, the CCT has seen providers to refuse to participate in the PRC program. The Colville Reservation is in a rural, low-income area where there are only a small number of providers to begin with, so the loss of a provider participating in the PRC program because of non-payment by IHS is devastating.

The Colville Tribes has provided the Committee with language that would amend section 222 of the IH CIA to clarify IHS's duties to inform providers that the IHS beneficiaries are not liable for PRC bills and require IHS to implement a reimbursement process for those IHS beneficiaries who pay PRC bills that IHS does not pay. We urge the Committee to consider including this language in Title I of the Act.

QUESTIONS SUBMITTED FOR THE RECORD TO THE HON. CINDY MARCHAND,
SECRETARY, TRIBAL COUNCIL, CONFEDERATED TRIBES OF THE COLVILLE
RESERVATION

Ms. Marchand did not submit responses to the Committee by the appropriate deadline for inclusion in the printed record.

Questions Submitted by Representative Westerman

Question 1. Previous versions of the Restoring Accountability in the Indian Health Service Act included a section on medical chaperones.

Do you believe there still a need for medical chaperones for patients at IHS facilities? If so, please elaborate on what language should be added to this discussion draft to address the issue.

Question 2. Recruitment and retention of health care personnel are two issues this committee has heard about time and time again, especially in rural areas. The entire health care system faces challenges of hiring and retaining medical professionals.

2a) Anecdotally, what barriers do you know medical professionals face to work at either IHS or tribally run health care programs?

2b) What have you seen in tribally run health care programs regarding improvements to hiring and recruitment that could help IHS fill their staff vacancies and improve employee retention?

2c) What sections of this discussion draft could help with recruitment and retention of personnel the most?

Question 3. There have been reports regarding the lack of accountability when it comes to IHS employees and misconduct.

3a) Anecdotally, can you provide any examples of complaints toward IHS medical staff not being taken seriously by IHS officials?

3b) Are you aware of any incidents that have not been previously reported where an IHS employee retained their position despite complaints being raised against them?

3c) Are the protections provided in this discussion draft enough for IHS employees to raise objections and be certain they are safe to do so?

Question 4. The NIHB raised the question of reimplementing a tribal advisory committee like the National Steering Committee to Reauthorize of the Indian Health Care Improvement Act (IH CIA) that had previously advised the federal government about changes to the IH CIA, prior to its permanent reauthorization.

4a) Would your tribe be supportive of that sort of committee being established? What if the tribal leaders who serve on the committee would serve without pay?

4b) What other advisory committees or councils that are currently established in HHS or IHS that could be used to provide the expertise the National Steering Committee previously provided?

4c) What further ways aside from a national steering committee may be beneficial to institute so IHS will have more input from tribes on how to improve IHS policies and procedures?

Question 5. Concerns were raised in NIHB written testimony about the discussion draft affecting tribally run health programs that have been compacted or contracted out from IHS.

5a) What sections of this discussion draft could most affect tribally operated health programs and how?

5b) What language do you think should be included to reduce that effect?

5c) Are there aspects of this discussion draft that would improve tribal autonomy and control over tribally run health programs?

Question 6. From your perspective, what regulations and official guidance from IHS cause the largest challenges for tribal members seeking care? What about for tribes compacting or contracting out health care services from IHS?

Question 7. In your testimony you explained that Confederated Tribes of the Colville Reservation were in the process of contracting out all IHS related functions. Could you provide more background as to why that decision was made?

Question 8. In your testimony, you stated that provisions should be included to Section 101 to allow for incentives to be given to Service Unit CEOs as well as other upper management positions.

Could you elaborate on that idea and detail what kind of incentives you think should be made available?

Question 9. Your testimony discussed the “purchase/referred care” (PRC) program and how tribes use the program. its use for tribal entities, such as Colville. One of the core functions of the PRC programs is its availability to provide care when staffing at facilities fail to meet the needs of the patient base.

9a) Could you elaborate further on the various obstacles a tribe faces when utilizing the program?

9b) Are there specific implementation issues related to IHS staffing that could be addressed by the proposed changes in this legislation?

Question 10. In your testimony you outlined IHS has had significant carryover funds in the PRC program.

What would you recommend that IHS do with the PRC carryover that is has for the Colville Service Unit or the Portland Area?

Question 11. In your written testimony you stated frustrations with the staffing ratios at IHS, noting the limited ways that IHS will change the ratios—either through constructing a new facility under IHS’ “priority list,” or building a facility using Joint Venture funds.

11a) In your opinion, would the proposed “staffing demonstration program” found in Section 108 of the discussion draft address this issue?

11b) How else could the ratio be addressed by Congress to improve review of the ratios for all IHS areas?

Questions Submitted by Representative Leger Fernández

Question 1. A common theme throughout the hearing was the need for Congress to hear directly from tribes and tribal organizations across the country on any policies designed to improve direct or indirect IHS care for American Indians and Alaska Natives.

1a) How do you believe Congress should consult with Tribes on their unique experiences and perspectives to inform potential legislation to improve the Indian Healthcare Improvement Act (IHICIA)?

1b) One recommendation put forward was for Congress to support a National Steering Committee (NSC) process to examine necessary reforms to IHS and IHICIA. How do you believe Congress can best support Tribes in such processes to ensure policy outcomes are led by tribal leaders?

Ms. HAGEMAN. I thank the witness for her testimony.
The Chair now recognizes Mr. Lee Spoonhunter for 5 minutes.

**STATEMENT OF LEE SPOONHUNTER, BILLINGS AREA
REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD,
WASHINGTON, DC**

Mr. SPOONHUNTER. Chairwoman Hageman, Ranking Member Leger Fernández, and distinguished members of the Subcommittee, thank you for this opportunity to provide testimony on the “Restoring Accountability in the Indian Health Service Act.” My name is Lee Spoonhunter. I serve as a tribal council member for the Northern Arapaho Tribe and the Rocky Mountain Area representative for the National Indian Health Board.

This bill arises from our conflicted past with the United States and the staffing and accountability issues caused by chronic underfunding of the Indian Health Service, and how staffing shortages persist throughout Indian Country from top to bottom. Earlier this year, I had just testified that it has a 28 percent provider vacancy rate and a 40 percent mental health professional vacancy rate. The lack of providers forces IHS and tribal facilities to rely on contracted services, which can be more costly, less effective, and culturally inept.

We are supportive of the intent of this bill to address policy concerns at the IHS. However, we believe there is more work needed before there are any amendments to the Indian Healthcare Improvement Act. To that end, the bill should not supersede any consensus recommendations of the IHCIA National Steering Committee and should seek to empower collaborative policy development around IHS accountability on a government-to-government basis.

The draft bill has many well-intended provisions that seek to address past misconduct and a lack of accountability at the IHS, such as modifications to the IHS loan repayment plan, streamlined hiring practices, and culturally-appropriate, historically-accurate training for staff. The bill would also address best practices for IHS area offices and service unit governing boards as well as establish clear rules for misconduct and disciplinary action. Unfortunately, we are worried that the good intentions could negatively impact our sovereignty. It could set us on a path backward in U.S. tribal relations.

A number of issues addressed in this bill came up in the regional and national meetings on the reauthorization of the Indian Healthcare Improvement Act. For years, when it came to renewing or modifying IHCIA, there was a national steering committee charged with identifying the needed objectives and policy changes for the law. The national steering committee worked diligently to reach consensus on many issues, some of which were contentious and controversial.

We call upon Congress to support a national focused steering committee process again. We hear from tribal leaders that there is a lack of transparency around activities and decision-making at IHS, such as when a tribe receives its services directly through the IHS operator service unit. We are concerned that one of the issues

with IHS accountability is that there is not a clear and common understanding of what gives them to rise in the first place.

When policy is enacted, the impact is often pushed on direct service tribes with no explanation. We are concerned that this bill has been developed so far without national tribal consensus and could harm tribes and their past work. However, we will not study this problem away. There is no amount of red tape that can patch an underfunded system. Imagine having one day's worth of food for a week for generations.

The funding at IHS on one-seventh of the estimate of the tribal budget formulation work groups sets us up for failure. For example, at the Northern Arapaho, our tribal citizens are at a disadvantage for referred care. Those dollars are so limited that patients are not given the needed referrals until they are often too sick to receive curative treatment. We recently hired a nephrologist with our third-party revenue dollars, someone that would not likely have been hired if we had IHS direct care, who informed us that we could have greatly improved patient care and saved lives if the care was provided sooner. But the PRC dollars are so scarce it is often too late by the time they get the referral.

Thank you again for this hearing and the draft legislation addressing IHS staffing and accountability issues. I know that if we work together as sovereigns we can do so much more. I look forward to any questions you have. Thank you.

[The prepared statement of Mr. Spoonhunter follows:]

PREPARED STATEMENT OF COUNCILMAN LEE SPOONHUNTER, ROCKY MOUNTAIN AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD

Chairwoman Hageman, Ranking Member Leger Fernández, and distinguished members of the Subcommittee, on behalf of the National Indian Health Board and the 574 sovereign federally recognized American Indian and Alaska Native Tribal nations we serve, thank you for this opportunity to provide testimony on the Restoring Accountability in the Indian Health Service Act of 2023. My name is Lee Spoonhunter. I serve as Tribal Councilmember for the Northern Arapaho Tribe and Rocky Mountain Area Representative for the National Indian Health Board (NIHB).

Formed in 1972, NIHB is recognized nationally and internationally for its expertise in Indian health policy. NIHB's membership consists of the eleven Area Indian Health Boards (AIHBs) and the Tribes of the Tucson Area directly. NIHB supports Tribal policy through collaborative partnerships with Tribal, Congressional, federal, state, and International governmental and non-governmental organizations, as well as through original research and development, public education, and outreach.

The Indian Health Service (IHS) is the principal federal health care provider and health advocate for Indian people. Its success is essential to our success as an organization, and to meeting this Nation's stated policy goal of ensuring the highest possible health status for Indians. The NIHB, therefore, appreciates this Subcommittee's focus on Indian healthcare and stands ready to work with the Subcommittee toward achieving this national goal. We have a long way to go.

The NIHB Board of Directors sets forth an annual Legislative and Policy Agenda to advance the organization's mission and vision. Our objectives are to educate policymakers about Tribal priorities, advocate for and secure resources, build Tribal health and public health capacity, and support Tribally led efforts to strengthen Tribal health and public health systems. Today's testimony includes a subset of recommendations from this Agenda.

IHS Accountability

“For decades and generations, IHS has had a notorious reputation in Indian Country but it is all we have to count on. We do not go there because they have superior health care; we go there because it is our treaty right, and we go there because many of us lack the resources to go elsewhere.”

2016 Statement of Victoria Kitcheyan, Treasurer, Winnebago Tribal Council, to the Senate Committee on Indian Affairs.

The Restoring Accountability in the Indian Health Service Act of 2023 arises from our conflicted past relations with the United States and from the chronic underfunding of the United States treaty and trust obligations to provide for the health of Tribal nations and their citizens.¹ The NIHB is supportive of the intent of this draft legislation to address policy concerns at the IHS. However, we believe there is more work to be done to improve this legislation before there are any amendments to the Indian Health Care Improvement Act (IHCIA). To that end, the bill should not supersede any consensus recommendations of the IHCIA National Steering Committee (NSC) and should seek to empower collaborative policy development on a government-to-government basis.

Chronic and pervasive health staffing shortages—from physicians to nurses to behavioral health practitioners—stubbornly persist across Indian Country, with 1,550 healthcare professional vacancies documented as of 2016. Further, a 2018 Government Accountability Office (GAO) report found an average of 25% provider vacancy rates for physicians, nurse practitioners, dentists, and pharmacists across two thirds of IHS Areas (GAO 18-580). In May of this year, IHS Director Roselyn Tso testified before this Subcommittee that the agency currently has a 28% provider vacancy rate and a 40% mental health professional vacancy rate. This challenge is not getting better. Lack of providers also force IHS and Tribal facilities to rely on contracted providers, which can be more costly, less effective, and culturally indifferent, at best—inept at worst. Relying on contracted care reduces continuity of care because many contracted providers have limited tenure, are not invested in community and are unlikely to be available for subsequent patient visits. Along with a lack of competitive salary options, many IHS facilities are in a serious state of disrepair, which can be a major disincentive to potential new hires. While the average age of hospital facilities nationwide is about 10 years, the average age of IHS hospitals is nearly four times that—at 37 years. In fact, an IHS facility built today could not be replaced for nearly 400 years under current funding practices. As the IHS eligible user population grows, these aging facilities impose an even greater strain on availability of direct care.

NIHB is glad to see that the draft legislation would focus on improving staffing at the IHS. We must continue to think creatively about how to recruit and retain the best medical professionals to the Indian health system. We hope that we can continue this conversation about how to attract the best providers to the agency. We are also glad to see language to help improve and standardize the IHS. However, the policies identified in this bill must be done with the necessary appropriations to back them up. NIHB also supports ensuring that the legislation would not impact Tribal health programs negatively, and that the true needs of IHS are adequately reflected.

IHCIA and the National Steering Committee

A number of the issues addressed in the Restoring Accountability in the Indian Health Service Act of 2023 came up in the regional and national meetings on the reauthorization of the IHCIA. For years, when it came to renewing and modifying IHCIA, there was a National Steering Committee (NSC) that consisted of Tribal representatives from across the country. During this process there were multiple regional consultation meetings and a national consultation in Washington, DC. This process identified the needed objectives and policy changes for IHCIA. This allowed any amendments to IHCIA to be supported by Tribes and for Indian Country to speak with a unified voice. The NSC worked diligently to reach national consensus on many issues, some of which were contentious or controversial.

As we work with the Subcommittee to support and examine necessary reforms to IHS, we call upon Congress to support a nationally-focused NSC process again. This process would balance the perspectives and needs of the entire Tribal health system resulting in a consensus among Indian Country and stakeholders. The NIHB stands

¹See, U.S. Commission on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* (hereinafter “*Broken Promises*”), available at: <https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf>, accessed on: November 20, 2022.

with its partners and allies that any federal policymaking should be respectful of the Tribal leaders' decisions and policy outcomes that came through such process.

For example, NIHB consistently hears that there is that the lack of transparency around activities and decision making at IHS, particularly when a Tribe receives its services directly through an IHS operated service unit. NIHB partners are concerned that one of the issues with IHS accountability is that there is not a clear and common understanding of the rules and procedures that give rise to these issues. When policy is enacted regarding IHS, the impact of that policy is often thrust upon Tribes receiving direct services from IHS to bear regardless of whether the driving force of the underlying policy or decision is explained. The IHS Restoring Accountability Act, to our knowledge, was not a product of an NSC process. A considerable amount of the policy in this bill has been developed and proposed without national Tribal consensus and is at risk of inadvertently harming Tribal nations and Tribal health systems.

Treaties, Trust, and the Duty Owed

Tribal nations have a unique legal and political relationship with the United States as defined by the U.S. Constitution, treaties, statutes, court decisions, and administrative law. Through its acquisition of land and resources, the United States formed a fiduciary relationship with Tribal nations whereby it has recognized a trust relationship to safeguard Tribal rights, lands, and resources.² In fulfillment of this Tribal trust relationship, the United States “charged itself with moral obligations of the highest responsibility and trust” toward Tribal nations.³ This bargained for exchange means that Tribal nations paid, in full, for the duties owed by the United States and that the United States has to duty to uphold its end of the exchange, which it continues to generously benefit directly from.

The United States' long-standing and repetitive use of language regarding trust relationships and legal obligations is not by accident. In a trust relationship, a trustee owes certain fundamental duties to the beneficiaries, including a duty of loyalty to all beneficiaries, a duty to provide requisite resources, and a duty to act in good faith. The duty to provide requisite resources is not only one of quantity, but one of continuity and stability. Otherwise, the purpose of the trust relationship recognized by the United States for centuries is effectively meaningless.

Most recently, Congress reaffirmed its duty to provide for Indian health care when it enacted the Indian Health Care Improvement Act (IHCA) (25 U.S.C. § 1602), declaring that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.” Unfortunately, those responsibilities and legal obligations remain unfulfilled and Indian Country remains in a health crisis.

Today, most Tribal lands are held in trust by the United States or have been completely taken from our Nations through the long history of U.S. war, removal, assimilation, reorganization, and termination. As a result, Tribes do not have the same asset base or tax base as other governments. Tribal nations rely on federal government funding and on economic development, but infringement on Tribal tax jurisdiction and drastically reduced land bases leave most Tribal nations in a position of unique reliance on annual appropriations for their healthcare infrastructure and delivery.

The Health Status of Indian Country

The Centers for Disease Control and Prevention (CDC) now reports that life expectancy for AI/ANs has declined by nearly 7 years, and that our average life expectancy is now only 65 years—equivalent to the nationwide average in 1944.⁴ With a life expectancy *10.9 years less than the national average*,⁵ Native Americans die at higher rates than those of other Americans from chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory disease.⁶ Native American women

² *Worcester v. Georgia*, 31 U.S. 515 (1832).

³ *Seminole Nation v. United States*, 316 U.S. 286, 296–97 (1942).

⁴ U.S. Department of Health and Human Services, *Centers for Disease Prevention and Control, Provisional Life Expectancy Estimates for 2021* (hereinafter, “*Provisional Life Expectancy Estimates*”), Report No. 23, August 2022, available at: <https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf>, accessed on: October 13, 2022 (total for All races and origins minus non-Hispanic American Indian or Alaska Native).

⁵ *Id.*

⁶ *Broken Promises* at 65.

are 4.5 times more likely than non-Hispanic white women to die during pregnancy.⁷ Between 2005 and 2014, every racial group experienced a decline in infant mortality except for Native Americans⁸ who had infant mortality rates 1.6 times higher than non-Hispanic whites and 1.3 times the national average.⁹ Native Americans are also more likely to experience trauma, physical abuse, neglect, and post-traumatic stress disorder.¹⁰ AI/ANs experience the highest rates of suicide according to a 2020 SAMHSA study,¹¹ with a recent, February 2023 CDC report finding that teen girls are experiencing record high levels of violence, sadness, and suicide risk.¹² Additionally, Native Americans experience some of the highest rates of psychological and behavioral health issues as compared to other racial and ethnic groups¹³ which have been attributed, in significant part, to the ongoing impacts of historical trauma.¹⁴

The Resources Provided to the Indian Health Service

Although annual appropriations for IHS have consistently increased since 2009, after adjusting for inflation and population growth, the IHS budget has remained static in recent decades. In December 2018, the U.S. Commission on Civil Rights' *Broken Promises* report found that Tribal nations face an ongoing funding crisis that is a direct result of the United States' chronic underfunding of Indian health care for decades, which contributes to vast health disparities between Native Americans and other U.S. population groups. We saw this crisis manifest in the worst way possible during the COVID-19 pandemic, and now we see it in the latest data and reporting.

Supplemental appropriations enacted during the pandemic were historic investments for Indian Country. It cannot be lost to history that the United States' swift action saved lives, but it must also be clear that the IHS is so disproportionately underfunded by Congress that a historic investment in response to a global virus still provided less resources than the estimate of annual obligations for IHS services in a single year—an amount collaboratively developed by the IHS National Tribal Budget Formulation Workgroup (NTBFW). For comparison, the latest enacted regular appropriations for IHS totals about \$7 billion, or roughly 7 times less than the need-based estimate from the Workgroup for FY 2023.

Imagine having only one day's worth of food for a week: for generations. Imagine if the federal government asked you why you are so hungry all the time when they 'already gave you food,' why you can't manage your groceries like someone with a full pantry when they took nearly all of your resources. This staggering comparison underscores the purposeful inequity that continues to result in American Indians and Alaska Natives (AI/ANs) having some of the worst health outcomes of any U.S. population. Surely, this cannot be the highest possible health status promised by the United States in the IHCA.

We understand and appreciate the need for Congress to embrace fiscal restraint and balancing the national debt. However, our ancestors have already prepaid for health care. This is not a new or "nice to have" program. IHS is an essential program that is the fulfillment of sacred promises made to Tribal nations. It is time that the U.S. Congress finally live up to these obligations and provide his with adequate funding. We cannot expect the Indian health system to improve when it does not have the resources it needs.

⁷ *Broken Promises* at 65.

⁸ *Broken Promises* at 65.

⁹ *Broken Promises* at 65.

¹⁰ *Broken Promises* at 79–84.

¹¹ Substance use And Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States, Results from the 2020 National Survey on Drug Use and Health*, available at: <https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFR1PDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf>, accessed on: March 22, 2023.

¹² Centers for Disease Control and Prevention, *Press Release: U.S. Teen Girls Experiencing Increased Sadness and Violence*, available at: <https://www.cdc.gov/media/releases/2023/p0213-yrbs.html>, accessed on: March 22, 2023.

¹³ Walls, et al., *Mental Health and Substance Abuse Services Preferences among American Indian People of the Northern Midwest*, *Community Mental Health J.*, Vol. 42, No. 6 (2006) at 522, <https://link.springer.com/content/pdf/10.1007%2Fs10597-006-9054-7.pdf>, accessed on: November 20, 2022.

¹⁴ Kathleen Brown-Rice, *Examining the Theory of Historical Trauma Among Native Americans*, Prof'l Couns, available at: <http://tpcjournal.nbcc.org/examining-the-theory-of-historical-trauma-among-native-americans/>, accessed on: November 22, 2022.

Just Like our Life Expectancy—U.S. Spending Policy is Stuck in the Termination Era

Regardless of the Fund source or authorizing provision, the United States is making an annual budget policy decision much like the dark Termination Era policies that we pretend are behind us. Tribes and their citizens originally had a system of health care delivery imposed on them that was intentionally insufficient. Meanwhile, States and local governments violated Tribes' tax jurisdiction, effectively rendering Tribal nations without a way to fund basic infrastructure and governance in often isolated and drastically reduced or wholly taken lands.

As part of this imposed system, the resources provided to IHS have been chronically underfunded and measurably unequal compared to investments in other U.S. populations. We see this systematic isolation, sovereign infringement, forced dependence, assimilation, and termination in the annual appropriations process each year. We feel it in our communities, and the outcomes and data have been placed before us. We cannot expect Tribal communities' health to improve when they are consistently starved for resources. Too often, Tribal nations are trapped in a federal funding structure operating on the assumption that only state governments are worthy of base funding, essentially, assuming that we do not exist as jurisdictional sovereigns.

IHS Restoring Accountability Act—Step in the Right Direction

The IHS Restoring Accountability Act is well intentioned, and we sincerely appreciate the work that the subcommittee has undertaken to elevate the quality of care challenges at IHS. The legislation does move the needle forward in some respects by expanding eligibility on student loan repayment and the types of providers required to complete Tribal culture and history training. Below, we offer some comments on specific areas of the draft legislation.

- **SEC. 104: Clarification regarding eligibility for Indian Health Service loan repayment program.** Loan repayment programs are smaller in scale, when considering their availability to individuals, than loan forgiveness programs. Expanding the eligibility requirements of the Indian Health Service Loan Repayment Program (IHSLRP) to include individuals willing to serve in half-time practice and individuals with master's degrees in health care programs who are also certified in business administration and health-related fields could result in an increase of applicants for employment. Additionally, this program addresses the broad employment need and ongoing shortage of employees by providing employment in exchange for assistance with student loans rather than outright forgiveness. To further address employment vacancies, payments made through the IHS loan repayment program should be tax exempt. Making this assistance tax exempt, as it is for other federally-operated health care loan repayment programs, would help address the workforce shortages at IHS and throughout Indian Country.
- **SEC. 105: Improvements in Hiring Practices.** We are glad to see language in the bill that would improve on IHS' ability to quickly hire medical professionals. Too often, we hear stories of critical staff being lost to IHS because the federal hiring process is too burdensome and bureaucratic. We also agree with the language in the bill to provide notice to Tribal nations on key personnel changes. NIHB looks forward to working with Tribal nations and the committee to think of creative ways to recruit and retain medical professionals in a timely and efficient manner.
- **SEC. 107. Tribal Culture and History.** The legislation accurately addresses the need to strengthen and expand the current training requirements for culture and history provided in IHClA. While issues regarding the creation of training curriculum and consultation of Tribes on the curriculum is not discussed, requiring the training be mandatory and completed annually is a step in the right direction. Expanding the list of individuals required to complete the training to include employees, volunteers, and contractors allows for more culturally aware and educated employees providing care to every individual.
- **SEC 108. Staffing Demonstration Program.** In this section the bill would direct IHS to carry out a demonstration project in which IHS may provide federally managed Service units with staffing resources. Staffing is a key challenge for health care providers everywhere. The creative demonstration project at these facilities could impact long-term staffing. However, we urge the Subcommittee to work with Tribal nations to examine how this provision

could be more broadly expanded throughout the IHS and Tribal health system. We also would urge that critical resources are appropriated as part of this project.

- **SEC. 111. Enhancing Quality of Care in the Indian Health Service.** Section 111 requires HHS to consult with Indian tribes, governing boards, Area offices, Service units, and other stakeholders and establish best practices for governing boards and Area offices. The language contained in this section is thorough and will go a long way in standardizing care for IHS patients and improving the overall safety of the IHS. However, Congress must ensure that it is fully funded for it to have a significant impact.

Overarching Impacts:

Self-Governance Impact. Certain provisions in the bill would require the IHS to adopt policies or practices that would impact compacting and contracting pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA). For example, Section 111 of the draft bill requires the Secretary of HHS to establish best practices provisions for governing boards and for Area offices and ultimately “adopt” those best practices, but there is no apparent shield from the effects of that adoption for Tribes that enter into ISDEAA agreements. On its face, the language appears to intend to address best practices at IHS-operated Service units, but the definitions used for the purpose of this section would include tribal health programs operated by a Tribe or Tribal organization through an ISDEAA agreement. Policies such as draft Section 111 put forward without an exemption for Tribes or Tribal organizations that enter into ISDEAA agreements could result in policies that infringe on the notions of Tribal sovereignty and self-determination that were and are the fundamental policy underpinnings of ISDEAA. Further, it undermines the government efficiency aspects of ISDEAA compacts and contracts because it could add another compliance layer to operations that are a return to the United States telling Tribes how their treaty and trust rights should be structured.

With respect to the impacts of this draft bill on contracting and compacting under ISDEAA, it is important to note that draft section 111 is a single example of how well-intended policies may impact tribal sovereignty and self-determination in ways that were not intended or expected. NIHB is not an ISDEAA compact or contract negotiator for Tribal nations, and the potential for impacts on self-determination or ‘638’ contacting and self-governance compacting expand beyond that of draft Section 111 in the bill. One solution may be to include a section in the bill that clarifies that none of the bill’s provisions are intended to have an impact on tribally-operated programs, unless a tribe specifically agrees otherwise. NIHB continues to collaborate with its partners to identify these provisions and propose solutions, but the activity, again, underscores why outreach to Tribal nations from this Committee is absolutely necessary to identify these concerns and develop policy solutions on a government-to-government collaborative basis.

Unfunded mandates. This draft bill has twenty-four sections, seven of the sections specifically add additional reporting requirements for IHS and five others establish additional programs to be created and implemented by either HHS or IHS. Many sections, like section 111: Enhancing Quality of Care in the Indian Health Service, add more than one additional reporting requirement for multiple different agencies including but not limited to The Department of Health and Human Services, IHS, the Centers for Medicare and Medicaid Services, and GAO. While many of the reporting requirements and programs outlined in the draft bill are well intentioned, and likely needed, Congress must provide appropriated funds for these actions to occur. Additional transparency from IHS is essential in improving care and ensuring that the scarce dollars appropriated to IHS are well spent. But time and time again, Congress enacts legislation that places yet another barrier on Indian Country receiving access to quality healthcare. Mandatory appropriations for the IHS are consistent with the trust responsibility and treaty obligations reaffirmed by the United States in IHCA. It’s time for Congress to provide essential appropriated funding, otherwise this legislation will be another set of unfunded challenges at IHS.

Additional Key Policy Recommendations:

In addition to the comments below, we would like to reiterate some policy recommendations to improve and enhance the Indian Health Service.

- **Expansion of Tribal Self Governance for the Special Diabetes Program for Indians (SDPI):** Tribes and Tribal organizations have repeatedly called for a change to the Special Diabetes Program for Indians (SDPI) program structure to allow recipients the option to receive funding through 638 contracts and compacts which would allow for self-determination and self-governance. This would establish SDPI as an essential health service, remove the culturally inappropriate competitive grant structure, prevent the unnecessary federal administrative burden, and support Tribal sovereignty by transferring control of the program directly to Tribal governments.

Data sharing with IHS operated sites and TECs: CDC data from 2021 show that rates of syphilis are increasing exponentially for American Indians and Alaska Natives nationwide, far outpacing the national average. Despite these high rates, Tribal Epidemiology Centers have not been told the number of infant deaths from syphilis by any state or federal agency. Up to 40% of infants born to mothers with untreated syphilis can be stillborn or die. Great Plains Tribal Leaders' Health Board and its Tribal Epi Center along with Great Plains Area Tribes have asked, repeatedly, for more information around the syphilis outbreak to help better monitor and address the devastating syphilis rates in the region. But it has not be provided by IHS. Without this data, TECs and Tribes cannot target prevention and education activities; provide testing and treatment to those who need it most; or ensure that not one more Native baby is born with congenital syphilis.

This is just one example of a serious issue. This happens time and again where our Tribes and TECs are not given access to data that they are entitled to receive by law. It is critical that leadership at the highest level take immediate action.

- **Authorize full mandatory funding for all IHS programs.** Through its coerced acquisition of land and resources and genocide destruction of cultures and peoples the United States formed a fiduciary relationship with Tribal nations whereby it has created a trust relationship to safeguard Tribal rights, lands, and resources. As part of this coerced exchange, Congress has continuously reaffirmed its duty to provide for Indian health care. Unfortunately, Tribal nations face an ongoing health crisis directly resulting from the United States' chronic underfunding of Indian health care for decades. This contributes to ongoing health and persistent inequities and disparities. Mandatory appropriations for the IHS are consistent with the trust responsibility and treaty obligations reaffirmed by the United States in IHCA. Even today, 13 years after IHCA was permanently enacted, many provisions of IHCA remain unfunded and without implementation. Full and mandatory funding must include the full implementation of all authorized IHCA provisions.

Until Congress passes full mandatory funding for all IHS programs, the NIHB urges Congress to pass the following incremental funding measures:

- a. **Authorize mandatory funds for Contract Support Costs and 105(l) Lease Payments.**

As the Appropriations Committee has reported for years, certain IHS account payments, such as Contract Support Costs and Payments for Tribal Leases, fulfill obligations that are typically addressed through mandatory spending. Inclusion of accounts that are mandatory in nature under discretionary spending caps has resulted in a net reduction on the amount of funding provided for Tribal programs and, by extension, the ability of the federal government to fulfill its promises to Tribal nations.

- b. **Permanently Authorize discretionary advance appropriations.**

Advance appropriations for the IHS marks a historic paradigm shift in the nation-to-nation relationship between Tribal nations and the United States. With advance appropriations, AI/ANs will no longer be uniquely at risk of death or serious harm caused by delays in the annual appropriations process. NIHB urges Congress to pass a bill authorizing annual advance appropriations for all areas of the IHS budget and providing for increases from year

to year that adjust for inflation, population growth, and necessary program increases. NIHB supports advance appropriations until full, mandatory appropriations are enacted.

c. Protect the IHS budget from “sequestration” cuts.

The IHS budget remains so small in comparison to the national budget that spending cuts or budget control measures would not result in any meaningful savings in the national debt, but it would devastate Tribal nations and their citizens. As Congress considers funding reductions in FY 2024, IHS must be held harmless. As we saw in FY 2013 poor legislative drafting subjected our tiny, life-sustaining, IHS budget to a significant loss of base resources. Congress must ensure that any budget cuts—automatic or explicit—hold IHS and our people harmless.

d. Authorize federally-operated health facilities and IHS headquarters offices to reprogram funds at the local level in consultation with Tribes.

The Indian Self-Determination and Education Assistance Act (ISDEAA) authorized Tribal nations to take greater control over their own affairs and resources by contracting or compacting with the federal government to administer programs that were previously managed by federal agencies. This includes the ability to develop and implement their own policies, procedures, and regulations for the delivery of these services. Tribal nations may also receive direct services from the IHS. Unfortunately, some of the flexibility that makes ISDEAA so cost effective at delivering services is not available at the local level when direct services are provided by the IHS. Fundamentally, the ability to direct resources is one of Tribal sovereignty and self-determination. Just because a Tribe chooses to receive direct services from IHS does not mean it forfeits these rights. IHS must have greater budget flexibility, especially at the local service unit level to reprogram funds to meet health service delivery priorities, as directed by the Tribes who receive services from that share of the IHS funding.

e. Authorize Medicaid reimbursements for Qualified Indian Provider Services.

In 1976, Congress gave the Indian health system access to the Medicaid program in order to help address dramatic health and resources inequities and to implement its trust and treaty responsibilities to provide health care to AI/ANs and today, Medicaid remains one of the most critical funding sources for the Indian health system. In order to ensure that States not bear the increased costs associated with allowing Indian health care providers access to Medicaid resources, Congress provided that the United States would pay 100 percent of the costs for services received through Indian health care providers (100 percent FMAP). While Congress provided equal access to the Medicaid program to all Indian health care providers, in practice access has not been equal. Because States have the option of selecting some or none of the optional Medicaid services, the amount and type of services that can be billed to Medicaid varies greatly state by state. So, while the United States’s trust and treaty obligations apply equally to all tribes, it is not fulfilling those obligations equally through the Medicaid program. To further the federal government’s trust responsibility, and as a step toward achieving greater health equity and improved health status for AI/AN people, we request that Congress authorize Indian health care providers across all states to receive Medicaid reimbursement for a new set of Qualified Indian Provider Services. These would include all mandatory and optional services described as “medical assistance” under Medicaid and specified services authorized under the IHCA when delivered to Medicaid-eligible AI/ANs. This would allow all Indian health care providers to bill Medicaid for the same set of services regardless of the state they are located in. States could continue to claim 100 percent FMAP for those services so there would be no increased costs for the states for services received through IHS and tribal providers.

Conclusion

For the last 47 years, the United States has had a policy of ensuring the highest possible health status for Indians and to provide all resources necessary to affect that policy. Unfortunately, those responsibilities and legal obligations remain

unfulfilled and Indian Country remains in a health crisis. Clearly, the status quo isn't working.

Time will tell if today's hearing on the challenges and opportunities for improving healthcare delivery in Tribal communities marked the beginning of significant change, or the continuation of the status quo. The challenges are many, but most are equally matched by the opportunities and solutions already identified by Tribal leaders, Congresses, and Administrations past and present.

There is a way forward if Congress can overcome perhaps the greatest remaining challenge: political will. NIHB recognizes that the recommendations offered in this testimony will require coordination with other committees of jurisdiction, and we stand ready to help with that effort. But the heavy lifting must be borne by this Subcommittee. No other subcommittee in the House is as focused on Indian affairs as this one. At the same time, as noted earlier, we encourage Congress to support an NSC process that would allow for Tribes to advocate for needed changes to IHCA with one united voice. This process is critical to ensure that the changes only improve, and do not cause unintentional harm for the Indian health system. For the sake of our People, we hope this Subcommittee in the 118th Congress is up to the challenge.

Thank you again for the opportunity to offer testimony on this legislation today. We are happy to answer any questions you might have.

QUESTIONS SUBMITTED FOR THE RECORD TO MR. LEE SPOONHUNTER, BILLINGS AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD

Mr. Spoonhunter did not submit responses to the Committee by the appropriate deadline for inclusion in the printed record.

Questions Submitted by Representative Westerman

Question 1. Previous versions of the Restoring Accountability in the Indian Health Service Act included a section on medical chaperones.

Is there still a need for medical chaperones for patients at IHS facilities? And if so, please elaborate on what language should be added to this discussion draft to address the issue.

Question 2. Recruitment and retention of health care personnel are two issues this committee has heard about time and time again, especially in rural areas. The entire health care system faces challenges of hiring and retaining medical professionals.

2a) Anecdotally, what barriers do you know medical professionals face to work at either IHS or tribally run health care programs?

2b) What have you seen in tribally run health care programs regarding improvements to hiring and recruitment that could help IHS fill their staff vacancies and improve employee retention?

2c) What sections of this discussion draft could help with recruitment and retention of personnel the most?

Question 3. There have been reports regarding the lack of accountability when it comes to IHS employees and misconduct.

3a) Anecdotally, can you provide any examples of complaints toward IHS medical staff not being taken seriously by IHS officials?

3b) Are you aware of any incidents that have not been previously reported where an IHS employee retained their position despite complaints being raised against them?

3c) Are the protections provided in this discussion draft enough for IHS employees to raise objections and be certain they are safe to do so?

Question 4. NIHB raised the question of reimplementing a tribal advisory committee like the National Steering Committee to Reauthorize of the Indian Health Care Improvement Act (IHCA) that had previously advised the federal government about changes to the IHCA, prior to its permanent reauthorization.

4a) Would your organization be supportive of that sort of committee being established? What if the tribal leaders who serve on the committee would serve without pay?

4b) What other advisory committees or councils that are currently established in HHS or IHS that could be used to provide the expertise the National Steering Committee previously provided?

4c) What further ways aside from a national steering committee may be beneficial to institute so IHS will have more input from tribes on how to improve IHS policies and procedures?

Question 5. Concerns were raised in NIHB written testimony about the discussion draft affecting tribally run health programs that have been compacted or contracted out from IHS.

5a) What sections of this discussion draft could most affect tribally operated health programs and how?

5b) What language do you think should be included to reduce that effect?

5c) Are there aspects of this discussion draft that would improve tribal autonomy and control over tribally run health programs?

Question 6. From your perspective, what regulations and official guidance from IHS cause the largest challenges for tribal members seeking care? What about for tribes compacting or contracting out health care services from IHS?

Question 7. In your testimony, NIHB raised concerns regarding unfunded mandates and programs included in this discussion draft.

7a) Does NIHB have concerns with these programs specifically, or are the concerns only about funding?

7b) If IHS has already begun to institute some of these policies and programs with their current funding, does that change NIHB's position?

Questions Submitted by Representative Leger Fernández

Question 1. A common theme throughout the hearing was the need for Congress to hear directly from tribes and tribal organizations across the country on any policies designed to improve direct or indirect IHS care for American Indians and Alaska Natives.

1a) How do you believe Congress should consult with Tribes on their unique experiences and perspectives to inform potential legislation to improve the Indian Healthcare Improvement Act (IHCA)?

1b) One recommendation put forward was for Congress to support a National Steering Committee (NSC) process to examine necessary reforms to IHS and IHCA. How do you believe Congress can best support Tribes in such processes to ensure policy outcomes are led by tribal leaders?

Ms. HAGEMAN. Thank you, Mr. Spoonhunter, for your testimony. The Chair now recognizes Ms. Jerilyn Church for 5 minutes.

STATEMENT OF JERILYN CHURCH, EXECUTIVE DIRECTOR, GREAT PLAINS TRIBAL LEADERS HEALTH BOARD, RAPID CITY, SOUTH DAKOTA

Ms. CHURCH. Good afternoon, Chairwoman Hageman, Ranking Member Fernández, distinguished members of the Subcommittee, and Representative Johnson, thank you so much for the opportunity to be here this afternoon and to share my thoughts and testimony on the discussion draft for "Restoring Accountability in the Indian Health Service."

On behalf of the Great Plains Tribal Leaders Health Board, my name is Jerilyn Church. I am a member of the Cheyenne River Sioux Tribe. I serve as the President and CEO of the Great Plains Tribal Leaders Health Board and the Oyate Health Center in Rapid City, South Dakota.

We serve as a liaison between the tribes in the Great Plains, North Dakota, South Dakota, Nebraska, and we have one member tribe in Iowa, and we represent the tribes on various Health and Human Services divisions, including the Indian Health Service.

In our region, the Indian Health Service is the primary source of healthcare for nearly 150,000 American Indians and Alaska Natives in the Great Plains area. So, we are acutely aware of the difficulties and challenges within the Indian Health Service and of the need to improve healthcare delivery and health outcomes for Indian people in our communities. In fact, this past spring, I had the opportunity to testify before this Subcommittee on some of these challenges and appreciate the members of this Subcommittee placing an emphasis on improving IHS and its operations.

This draft legislation brings up important improvements, improving IHS management, the whistleblower protections, provision for housing, strengthening training requirements, the establishment of a compliance assistance program and, of course, providing for transparency in CMS surveys. However, we believe that there are additional opportunities to improve the language.

One of the concerns that we have is that in order to make changes and improvements, IHS is already under-resourced significantly, so any changes and improvements that are put forward need to be funded adequately to make meaningful change. We don't want it to become an issue where there are additional red tape or additional reporting requirements that take away from healthcare delivery, but strengthen already existing provisions that the Indian Health Service is required to provide that they may not be. We don't want it to be so burdensome that we end up just adding additional barriers to improve healthcare.

We want to make sure that there is parity between tribally-operated systems and direct service units that are managed directly by IHS. That is a really important distinction. If the language is not written in such a way that doesn't make those distinctions, then there becomes an issue of tribes that are already running their systems perhaps not being able to have the same flexibilities that they had before and to be innovative, which is one of the main reasons why tribes pursue self-determination and self-governance so that they can work outside of some of the parameters and red tape that Indian Health Service sometimes has that gets in the way.

The Health Board is happy to work with the members of the Subcommittee on suggestions. As my colleague here stated, one of the most effective mechanisms for tribal leaders to lend a voice and share their knowledge and wisdom was through the national steering committee on the reauthorization of the Indian Healthcare Improvement Act. So, we would strongly urge the members of the Subcommittee to work with your colleagues to direct Indian Health Service to reinstate that committee.

We thank you again for this opportunity to provide testimony today. This is a critical issue in the Great Plains. And, again, appreciate the opportunity to work with you to improve healthcare delivery for our people. [Speaking Native language.]

[The prepared statement of Ms. Church follows:]

PREPARED STATEMENT OF JERILYN LEBEAU CHURCH, GREAT PLAINS TRIBAL LEADERS
HEALTH BOARD

Thank you for this opportunity to present testimony on the discussion draft of the “Restoring Accountability in the Indian Health Service Act of 2023” on behalf of the Great Plains Tribal Leaders Health Board (GPTLHB). GPTLHB serves as a liaison between the Great Plains Tribes and the various Health and Human Services divisions, including the Great Plains Area Indian Health Service (IHS), and works to reduce public health disparities and improve the health and wellness of American Indian people and Tribal communities across the Great Plains. In our region, the Indian Health Service (IHS) is the primary source of health care for nearly 150,000 American Indians/Alaska Natives in the Great Plains Area. Of the six hospitals in the Great Plains, five are managed directly by IHS. Of the 13 ambulatory health clinics in the Great Plains Area, seven are managed entirely by a tribe or a tribal organization under a Title I Self-Determination contract, and five are managed directly by IHS. One is tribally managed through a Title V Self Governance compact. In addition, the Indian Health Service is responsible for two substance abuse treatment centers and supports three urban health care programs.

Therefore, at GPTLHB, we are acutely aware of the difficulties and challenges the IHS faces in improving healthcare delivery and healthcare outcomes for Indian people in our communities. In fact, just this spring, I testified before this Subcommittee on these current challenges and opportunities. We appreciate the members of this Subcommittee’ placing an emphasis on improving the IHS and its operations. This draft legislation raises several important issues and proposes important improvements to the system, including;

- improvements to IHS management;
- employee whistleblower protections;
- the provision for housing vouchers for recruitment and retention;
- strengthening the training requirements for tribal culture and history;
- the establishment of a compliance assistance program; and
- providing for transparency in CMS surveys.

We do, however, have concerns about the legislation as drafted. These include the need to make sure that the legislation does not confer additional unfunded mandates on the already seriously under-resourced IHS and that additional administrative requirements (including agency reporting requirements) will not be so burdensome as to take time and resources away from patient care. Concerning improvements to IHS operations, ensuring the agency has sufficient resources to do its job is the most crucial factor. It is also essential to make sure that the legislation does not duplicate authorities that IHS already has and that it maintains parity between Tribally operated healthcare facilities and programs where appropriate. It is also essential that Tribal facilities and programs are allowed to opt into or not participate in certain IHS-specific requirements imposed by the bill, such as the proposed uniform medical credentialing system. As legislation is passed to ensure that it is implemented in ways most appropriate to balancing IHS and tribal concerns, we recommend that the legislation require negotiated rulemaking where representatives of IHS and tribes around the country can meet together to determine the most effective implementation.

GPTLHB is happy to work with the Members of the Subcommittee on suggestions for improvements to the legislation as drafted, but the discussion draft—and the issues underlying it—raise the larger question of the process of including Tribal voices in potential legislative improvements through amendments to the Indian Healthcare Improvement Act (IHCA). In the past, these legislative efforts would primarily be driven by input from the knowledge, wisdom, and difficult decision-making of the Tribal leaders who made up the National Steering Committee (NSC) on the Reauthorization of the IHCA. Now that the IHCA has been made permanent, that mechanism for critical Tribal input no longer exists. We strongly urge the Members of the Subcommittee to work with your colleagues to direct IHS to reinstate the NSC and to provide sufficient appropriations to support its critical work.

Thank you for the opportunity to provide testimony today on this critical issue and for your efforts to improve healthcare delivery to all our People and communities.

QUESTIONS SUBMITTED FOR THE RECORD TO MS. JERILYN CHURCH, EXECUTIVE
DIRECTOR, GREAT PLAINS TRIBAL LEADERS HEALTH BOARD

Ms. Church did not submit responses to the Committee by the appropriate deadline for inclusion in the printed record.

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Question 1. Previous versions of the Restoring Accountability in the Indian Health Service Act included a section on medical chaperones.

Is there still a need for medical chaperones? And if so, please elaborate on what language should be added to this discussion draft to address the issue.

Question 2. Recruitment and retention of health care personnel are two issues this committee has heard about time and time again, especially in rural areas. The entire health care system faces challenges of hiring and retaining medical professionals.

2a) Anecdotally, what barriers do you know medical professionals face to work at either IHS or tribally run health care programs?

2b) What have you seen in tribally run health care programs regarding improvements to hiring and recruitment that could help IHS fill their staff vacancies and improve employee retention?

2c) What sections of this discussion draft could help with recruitment and retention of personnel the most?

Question 3. There have been reports regarding the lack of accountability when it comes to IHS employees and misconduct.

3a) Anecdotally, can you provide any examples of complaints toward IHS medical staff not being taken seriously by IHS officials?

3b) Are you aware of any incidents that have not been previously reported where an IHS employee retained their position despite complaints being raised against them?

3c) Are protections provided in this bill are enough for I-H-S employees to raise objections and be certain they are safe to do so?

Question 4. NIHB raised the question of reimplementing a tribal advisory committee like the National Steering Committee to Reauthorize of the Indian Health Care Improvement Act (IHCA) that had previously advised the federal government about changes to the IHCA, prior to its permanent reauthorization.

4a) Would your organization be supportive of that sort of committee being established, even if it would require tribal leaders who serve on the committee to serve without pay?

4b) What other advisory committees or councils that are currently established in HHS or IHS that could be used to provide the expertise the National Steering Committee previously provided?

4c) What further ways aside from a national steering committee may be beneficial to institute so IHS will have more input from tribes on how to improve IHS policies and procedures?

Question 5. In your testimony you mentioned the need to ensure that this discussion draft does not duplicate authorities IHS already has.

5a) Could you elaborate further on that point and provide examples of sections of the bill that may duplicate current IHS authorities?

5b) Are you aware of programs or policies within this discussion draft that IHS is already working to implement or improve and, if so, what are they?

Question 6. From your perspective, what regulations and official guidance from IHS cause the largest challenges for tribal members seeking care? What about for tribes compacting or contracting out health care services from IHS?

Question 7. During the hearing, you brought up concerns with the medical credentialing aspect of the legislation as well as tribal health program autonomy.

7a) What specific medical credentials could IHS institute that could be detrimental to tribally run medical facilities?

7b) *Could you elaborate on how the discussion draft should balance tribal autonomy and ensuring parity of care and credentialing occurs across both IHS and tribally run health programs?*

7c) *Is there anything else Congress should need to know to make the best policy decisions on this topic?*

Questions Submitted by Representative Leger Fernández

Question 1. A common theme throughout the hearing was the need for Congress to hear directly from tribes and tribal organizations across the country on any policies designed to improve direct or indirect IHS care for American Indians and Alaska Natives.

1a) How do you believe Congress should consult with Tribes on their unique experiences and perspectives to inform potential legislation to improve the Indian Healthcare Improvement Act (IHCA)?

1b) One recommendation put forward was for Congress to support a National Steering Committee (NSC) process to examine necessary reforms to IHS and IHCA. How do you believe Congress can best support Tribes in such processes to ensure policy outcomes are led by tribal leaders?

Ms. HAGEMAN. Thank you, Ms. Church. And we all agree that this is a very important issue, so, again, we appreciate you being here.

I believe they have called votes, but we are going to go ahead and have Mr. Carl do his 5 minutes of questioning just to make sure that we can get those in. So, Mr. Carl, if you would please proceed with 5 minutes of questioning.

Mr. CARL. Thank you, Madam Chairman, and thank you to the panel for coming and speaking and taking your time. Mr. Spoonhunter, it is always great to see you. We have developed a friendship over time. My question is targeted at you, but let me run through a list here real quick.

As you are aware, the Indian Health Services play a critical role in providing healthcare to the Native American community. It is evident that the Indian Health Services has been struggling with issues like substandard medical care, high staff vacancy rate, and I think we were around 50 percent a while ago when I heard some numbers talked about, and inadequacy of the facilities, making it hard for them to deliver quality healthcare to those who need it the most.

The Restoring of Accountability in the Indian Health Services Act aims to address various problems. One is the inability to retain quality healthcare professionals. I know that the Federal Government always feels like they have all the answers. I am one of those that don't believe that. I grew up digging ditches and working with my hands, and most of the answers, you have to go to the field to actually figure that out and talk to the people and learn what the problems truly are.

So, my question to you, in your experience, what measures do you believe this Act should include to effectively improve overall state of healthcare delivery in the Indian Health Services?

Mr. SPOONHUNTER. Thank you, Representative Carl, it is always good to see you here on the Hill. At Wind River, we have a very unique situation. We have two tribes there: the Eastern Shoshone and the Northern Arapaho. The Eastern Shoshone, the majority of

their tribal members go to a direct IHS funded facility which was built in the 1800s, that is still open today and still needs to be replaced. That is the standard that hopefully this bill will cover.

And then you have the Northern Arapaho who have taken the Arapaho Clinic there and they have 638 self-determination, took the resources from IHS and developed quality healthcare for our people there without the bureaucratic red tape that IHS has in place that sometimes prevents our tribal members from receiving the adequate quality care that they need. Through self-governance, we are able to have competitive wages for the medical team, doctors, nurses, all of the staff, with the surrounding Fremont County that we live in.

And we are also able to provide insurance and a 401(k) package that is a lot better than what IHS can provide. So, we retain a lot of our doctors, and a lot of our doctors have come and stayed with us. But it is through self-governance that we are so successful.

We have been able to take one clinic in of our communities and open up two clinics, one in Ethete, Wyoming and the one in Riverton, Wyoming which is on the neighboring town of the reservation. The Riverton Clinic is more visited than the reservation clinics because a lot of our tribal members have a lack of housing, so they have to stay in a neighboring town.

But the answer to your question is, it is through self-governance and through 638 that we are able to use our tribal sovereignty to provide better care to our tribal members, and we encourage our Eastern Shoshone tribal counterparts to do the same, and I know they are in that process now. But it is through, again, I say the bureaucratic red tape of IHS and what they have to endure that sometimes the quality of care for tribal members and Native American people gets lost in all of the government rules and regulations that IHS has to go through, and that is unfortunate.

It is unfortunate because we should be talking about quality healthcare for our people and a lot less rules and regulations. But with this bill, we look forward to continued dialogue so that we can get it right. We want to work with Congress and let's get it right once and for all.

Mr. CARL. Thank you, Mr. Spoonhunter. Might I make a suggestion? I would love to do a CODEL and go out and look at some of these places that these tribal members actually pick for us to look at, not for IHS to choose for us. I would like to go out there and look at it. My background is healthcare, I spent 35 years in it, in managing, so I would love to go out and look and see what they are actually dealing with. And if we could do that as a group, that would be great.

Ms. HAGEMAN. I think that is an excellent idea and we will work with staff to see if that is something that we can put together.

Mr. CARL. I yield back my time. Thank you.

Ms. HAGEMAN. Thank you very much. The Chair now recognizes Ms. Leger Fernández for her 5 minutes of questioning.

Ms. LEGER FERNÁNDEZ. Thank you so much for pointing out really the task before us, which is just how do we go about, (1), coming up with the ideas for the bill. And the issue of what I am hearing from you, Mr. Spoonhunter, is that going back to the

system of using the CSA, and I heard, Ms. Church, you say that as well. Do you agree with that, too? OK.

So, the process that you would like to see is to make sure that we are able to gather input from the wide range of tribes and tribal communities receiving healthcare.

Mr. Spoonhunter, the idea is that it is very distinct. Like in one reservation, you have a 638 compacted facility and then a direct, and what you see is very different. And I have helped build and set up health boards, and oh my god, it is amazing when you can end up having a joint venture facility, being able to staff it like it should be instead of, as you pointed out, frozen in time, was it 1927 or something? And that is key in being able to make those distinctions. So, I think that that is something that we really need to do.

So, this idea of a consultation process, can you just explain a little bit more how you would like that to look?

Ms. CHURCH. Yes, I will throw my two cents in there. The national steering committee that was established when the Indian Healthcare Improvement Act was reauthorized, and that no longer exists, but that body that consisted of tribal representation, tribal leaders from across all of Indian Country was the driving force. Their voice was the driving force to make the recommendations for what needed to happen to improve and update the Indian Healthcare Improvement Act.

At that time, that body, they were the primary authors. There are still some things that could be finessed with that, but it was tribal leadership, not Indian Health Service, that was driving those changes and that is what made the Indian Healthcare Improvement Act so much more effective and brought the opportunities that we have today.

Ms. LEGER FERNÁNDEZ. And in essence it was tribal leadership and also not Congress, right? We were listening to what was coming out of this process.

Ms. CHURCH. Exactly.

Ms. LEGER FERNÁNDEZ. Which was lengthy. If we don't act quickly, I mean, every day that we wait to get better services, it is heartbreaking, somebody dies, right, somebody is ill.

Mr. Spoonhunter, did you want to add something?

Mr. SPOONHUNTER. Yes, thank you, Representative Fernández. As a 638 and as a self-governance, it is the tribal leaders who oversee the clinic. We are responsible for the day-to-day activities of that clinic, as where in an IHS direct service we are not. And Ms. Church hit on a key point. Come to the tribal leaders, come to us, and when you are doing the consultation of this bill, and in working through what we need to fix, because it is not IHS that needs to fix it. As tribal leaders, the sovereign nations, we know what we need to do for our people to provide better healthcare. Just give us the opportunity. Thank you.

Ms. LEGER FERNÁNDEZ. Thank you. And, Ms. Church, you are in a very interesting position because you are in the process right now of building the joint venture facility, which meant you had to come up with the money, right? I have helped finance those. And not every tribe is going to be in that position. So, what is your recommendation to us for those tribes who are not in a position to finance a facility and/or compete for those joint venture slots?

Ms. MARCHAND. I am not sure what my recommendation would be. Obviously, more money. That is always a key. But, again, I think as those to the left of me have said, by going to those tribes and listening to what their needs are, possibly you may not find out it is as expensive as what they need.

So, I would say just going with the consultation and just finding out like what other programs or things that maybe we could do for them that may not be a joint venture or that magnitude but things that could improve their Indian Health Services through appropriations.

Ms. LEGER FERNÁNDEZ. OK, thank you so much, and we will submit any additional questions in writing because I think there is a lot of material that you have given us that we need to flesh out, so I truly appreciate it.

Ms. HAGEMAN. Thank you. The Chair now recognizes Mr. Johnson for 5 minutes of questioning.

Mr. JOHNSON. You are so very gracious, ma'am, thanks. I won't take the 5 minutes because you may want to get in before votes as well.

But first off, Ms. Church, I would just validate everything you were saying about being under-resourced. That is clearly a big part of the issue. I did like the distinction you drew, I think an important one between tribally-administered facilities and those that are directly administered.

Give us a little more meat on that bone. How specifically could we help strengthen this legislation by calling out those important distinctions?

Ms. CHURCH. Thank you. Yes, so I can give examples probably better than getting into the details. For instance, I think one of the recommendations in the bill was around credentialing and having a uniform credentialing process. I think that would work for Federal facilities that are managed directly by IHS. Some of our programs that are run by tribes, they may partner with another health system that may not be part of the Indian Health Service. So, there is flexibility that tribes and tribal organizations such as ours have to get creative with how to make our system work better.

Another example is our tribal sponsorship. One of the ways that Oyate Health Center helps to make our dollars go further is we have a tribal sponsorship program. We take a portion of our PRC dollars, and we buy insurance for a group of our beneficiaries who may not be eligible, meet the criteria for Medicaid, but don't have insurance. So, that is something that the Federal Government cannot do that we can do. We can purchase tribally-sponsored insurance that brings revenue back into our system and it helps those PRC dollars go a lot further. Those are a couple of examples.

Mr. JOHNSON. Oh, it is wonderful, and South Dakota is so grateful for your leadership, ma'am, thanks.

And, Madam Chair, I yield back.

Ms. HAGEMAN. Thank you for that. The Chair now recognizes myself for 5 minutes of questioning.

First of all, Mr. Spoonhunter, you were speaking my language in your testimony when you talked about the challenges associated with the over-regulation that comes from the IHS. What I would like to do, because I would think that it might take us 6 or 7 hours

if I were to ask you all of the regulations that create problems for you, I would like to have an opportunity to engage with you, since I represent the state of Wyoming, where you can perhaps identify for us, and we will send some written questions to this effect, that maybe you can identify some of those regulations that cause the largest challenges, maybe for one or two of your facilities, maybe for all of your facilities.

But I am a strong advocate, No. 1, in making sure that you have the autonomy to do what you need to do to take care of your tribal members, because I think you are going to be better at it than anybody out of Washington, DC. I am not trying to disparage anyone, I am just saying you care about the people there more than anyone here ever will, and it is just the reality. The closer you are to the situation, the more effective you are going to be.

So, I would like to identify some of those rules and regulations coming out of IHS, or HHS, or wherever it may be coming from that are causing the challenges that you have, and let's see if we can fix some of those as well.

In your testimony, Mr. Spoonhunter, you stated that the NIHB looks forward to working with Tribal Nations and the Committee to think of creative ways to recruit and retain medical professionals in a timely and efficient manner. I would also throw in there perhaps dental professionals because that is one of the other issues that has been brought to us repeatedly is the challenges of finding dental care for our tribal members.

So, the question I have for you is, could you please expand on what those creative ways could be and how they could align with the goals of the IHS staff recruitment and retention related to this particular draft legislation?

Mr. SPOONHUNTER. Thank you, Chairwoman. On the staffing levels that the IHS has had a problem with filling, again, yes, underfunding positions is a problem within IHS. We all know that. But that would just be a Band-Aid fix. We really need to sit down, with self-governance, at Wind River, we were able to get a person that would recruit our physicians, providers, nurses, and vet them through a very rigorous process, and we were able to also offer housing through the self-governance and through third-party billing.

As you know, in my area, the Billings area that I represent, Fort Peck cannot keep a doctor because there is no housing there. And I know this bill covers a housing voucher in a similar way, but we were able to also bring on the signing bonus for providers through the third-party billing. But, again, it is a lot of bureaucracy that IHS has to go through to hire. It takes a whole process.

I mean, we were talking today about an administrator position in one of the IHS service units that they had to raise the wage in order to hire someone to meet the qualifications of that job, and now that job has to wait 90 days because of IHS rules. That is an example of the bureaucracy that we have to wade through in order to hire someone of that administrative magnitude that will help direct these facilities.

So, again, it is a matter of allowing the tribes to come in and be part of that process and asking IHS these necessary questions that Congress I am sure that you have asked IHS, why does it take you

so long to hire someone, why are you not able to recruit and keep someone in that position. Those things are very critical.

And you talk about the dentist program. We are all scrambling to try to find dentists and retain dentists throughout Indian Country, and I know IHS is doing the same thing. But what can we do on a creative side that some of the self-governance 638 programs have done to recruit dentists? Let's look at their plans and what they did, because as tribes we are resourceful.

We are resourceful because we take what we have, and we make it work. And I think that the plans, like my colleague here Ms. Church said, have IHS sit down at the table with the tribal leaders and learn from us. We have taken self-governance 638 and we have done it better than what IHS could ever do.

Ms. HAGEMAN. OK. I appreciate that, and we want to learn from you. Ms. Marchand and Ms. Church, I would request the same thing, if you have ideas of how we can streamline this and address it.

One of the things in Wyoming, because we are the least populated state in the nation, and we only have one university, and we don't provide either dental training or medical training, so we have arrangements with other universities. We send our physicians to the University of Washington, UW, another UW, for example, and then we do the same thing with dental care, and then they come back to Wyoming and must spend, I believe it is, a minimum of 5 years practicing in the state of Wyoming, but they can get in-state tuition when they are going out of state to be able to receive that training.

I don't know if those are the kinds of programs that we could do with our tribal members as well, but I am absolutely willing to look at innovative ways to address this issue. I know Mr. Johnson is. I am extremely proud to have him with us on the Committee today for the hearing to talk about these things.

We do have to leave and go vote, so what I am going to say is that I really want to thank all of you for being here. I wish we could have spent a bit more time together. It is kind of a strange time for all of us. You have provided extremely valuable testimony. We are going to follow up with you because we do have additional questions.

The members of the Committee may have some additional questions for the witnesses, and we will ask you to respond to these in writing. Under Committee Rule 3, members of the Committee must submit questions to the Committee Clerk by 5 p.m. on Tuesday, August 1, 2023. The hearing record will be held open for 10 business days for these responses.

And if there is no further business, without objection, the Committee stands adjourned.

[Whereupon, at 3:14 p.m., the Subcommittee was adjourned.]

[ADDITIONAL MATERIALS SUBMITTED FOR THE RECORD]

Submission for the Record by Rep. Grijalva**Statement for the Record****United South and Eastern Tribes
Sovereignty Protection Fund****on H.R. ____, “Restoring Accountability in the Indian
Health Service Act of 2023”**

The United South and Eastern Tribes Sovereignty Protection Fund is pleased to provide testimony for the record of the House Natural Resources Subcommittee on Indian and Insular Affairs legislative hearing on the discussion draft of H.R. ____, The Restoring Accountability in the Indian Health Service Act of 2023. As we have indicated in the past, we can appreciate the intent of legislation to address shameful failures in the execution of the Indian Health Service’s (IHS) trust and treaty obligations to deliver quality health care to Tribal Nations and our citizens. However, it is disingenuous to ignore the decades of chronic underfunding of the agency and how IHS’ lack of resources contributes in large part to these failures. In addition, although we recognize that this bill remains a discussion draft, we underscore the need for thorough Tribal consultation to occur prior to further consideration. As written, we join our partners in expressing several concerns about the bill’s provisions. Although USET SPF supports reforms that will improve the quality of service delivered by the IHS, we continue to underscore the obligation of Congress to meet its trust and treaty obligations by providing full and mandatory funding to IHS and support additional innovative legislative solutions to improve the Indian Health System.

USET SPF is a non-profit, inter-tribal organization advocating on behalf of thirty-three (33) federally recognized Tribal Nations from the Northeastern Woodlands to the Everglades and across the Gulf of Mexico.¹ USET SPF is dedicated to promoting, protecting, and advancing the inherent sovereign rights and authorities of Tribal Nations and in assisting its membership in dealing effectively with public policy issues.

Chronic Underfunding Leads to IHS Failures

As the Subcommittee is well aware, Native peoples have endured many injustices as a result of federal policy, including federal actions that sought to terminate Tribal Nations, assimilate Native people, and to erode Tribal territories, learning, and cultures. This story involves the cession of vast land holdings and natural resources, oftentimes by force, to the United States out of which grew an obligation to provide benefits and services—promises made to Tribal Nations that exist in perpetuity. These resources are the very foundation of this nation and have allowed the United States to become the wealthiest and strongest world power in history. Federal appropriations and services to Tribal Nations and Native people are simply a repayment on this perpetual debt.

At no point, however, has the United States honored these sacred promises; including its historic and ongoing failure to prioritize funding for Indian Country. The chronic underfunding of federal Indian programs continues to have disastrous impacts upon Tribal governments and Native peoples. As the United States

¹USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Catawba Indian Nation (SC), Cayuga Nation (NY), Chickahominy Indian Tribe (VA), Chickahominy Indian Tribe—Eastern Division (VA), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mi’kmaq Nation (ME), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Monacan Indian Nation (VA), Nansemond Indian Nation (VA), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Pamunkey Indian Tribe (VA), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Rappahannock Tribe (VA), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), Upper Mattaponi Indian Tribe (VA) and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

continues to break its promises to us, despite its own prosperity, Native peoples experience some of the greatest disparities among all populations in this country and have for generations. It is no surprise, then, that the failures of the federal government to fund the IHS have come into horrifyingly sharper focus over the years and especially during the global pandemic. Decades of broken promises, neglect, underfunding, and inaction on behalf of the federal government left Indian Country severely under-resourced and at extreme risk during this COVID-19 crisis.

These long-term challenges are multi-faceted and cannot be solved overnight by one-size-fits-all reforms. Any efforts to reform IHS, through Congressional action or otherwise, must be accomplished through extensive Tribal consultation to reflect the complex challenges faced by different Tribal communities, including Tribally-operated healthcare facilities. Although USET SPF supports innovative legislative solutions to improve the Indian Health System and recognizes that policy improvements could be made, we continue to underscore the obligation of Congress to meet its trust responsibility by providing full funding to IHS. The federal trust responsibility obligates the federal government to provide quality healthcare to Tribal Nations which can only be accomplished when the Indian Health System is fully funded.

Full and Mandatory Funding for Federal Trust and Treaty Obligations

USET SPF celebrates and expresses its gratitude to this body for its role in the historic achievement of advance appropriations for the Indian Health Service (IHS). For the very first time, the agency's clinical services will have budgetary certainty in the face of continuing resolutions and government shutdowns. It is our expectation that appropriators will continue to include language providing advance appropriations for IHS beyond Fiscal Year (FY) 2024. We urge the inclusion of all of IHS' budget line items in this mechanism, as well as advance appropriations for all federal Indian agencies and programs as next steps for this Congress. Despite its importance in the stabilization of funding, however, we continue to view advance appropriations as a temporary funding mechanism in our overall advocacy for the full delivery of trust and treaty obligations.

Above all, the COVID-19 crisis has highlighted the urgent need to provide full and guaranteed federal funding to Tribal Nations in fulfillment of federal obligations. Because of our history and unique relationship with the United States, the federal government's trust and treaty obligations to Tribal Nations, as reflected in the federal budget, is fundamentally different from ordinary discretionary spending and should be considered mandatory in nature. Payments on debt to Indian Country should not be vulnerable to year to year "discretionary" decisions by appropriators. Honoring the first promises made by this country, in pursuing the establishment of its great principled democratic experiment, should not be a discretionary decision.

The Biden Administration's FY 2024 Request continues to propose a shift in funding for IHS from the discretionary to the mandatory side of the federal budget, including a 10-year plan to close funding gaps and an exemption from sequestration, a move that would provide even greater stability for the agency and is more representative of perpetual trust and treaty obligations. Year after year, USET SPF has urged multiple Administrations and Congresses to request and enact budgets that honor the unique, Nation-to-Nation relationship between Tribal Nations and the U.S., including providing full and mandatory funding. We continue to ask that Congress join us in genuine partnership, along with the Administration, to craft an enact this necessary change. We firmly believe that full and mandatory funding for the IHS is the only way to make meaningful inroads in the Agency's challenges. To suggest otherwise ignores the primary source of these challenges.

The FY 2024 Request also, once again, proposes mandatory funding for Contract Support Costs and 105(l) leases—binding obligations—at IHS, as well as the Bureau of Indian Affairs and the Bureau of Indian Education. While we contend that all federal Indian agencies and programs should be subject to mandatory funding, in recognition of perpetual trust and treaty obligations, we continue to support the immediate transfer of these lines to the mandatory side of the federal budget. This will ensure that funding increases are able to be allocated to service delivery, as opposed to the federal government's legal obligations. The Senate Interior Appropriations Subcommittee ultimately supported these important first steps in achieving mandatory funding for Indian Country in its mark for FY 2023. We now call Congress to work with Tribal Nations and the Administration fulfill its responsibilities and work to ensure that this proposal is included in any final FY 2024 appropriations legislation.

Expand Self-Governance Compacting and Contracting

The United States government bears a responsibility to uphold the trust obligation, and that obligation includes upholding Tribal sovereignty, self-determination, and self-governance. The Indian Self-Determination and Education Assistance Act (ISDEAA) authorizes the federal government to enter into compacts and contracts with Tribal Nations to provide services that the federal government would otherwise be obligated to provide under the trust and treaty obligations. Although self-government by Tribal Nations existed far before the passage of ISDEAA, Tribal Nations have demonstrated through ISDEAA authorities since the bill's enactment that we are best positioned to deliver essential government services to our citizens, including through the assumption of federal program and services. Tribal Nations are directly accountable to and aware of the priorities and problems of our own communities, allowing us to respond immediately and effectively to challenges and changing circumstances.

The success of self-governance under the ISDEAA is reflected in the significant growth of Tribal self-governance programs since its passage. In the USET region, the majority of our Tribal Nations engage in self-governance compacting or contracting to provide essential health care services. Across Indian Country, nearly two-thirds of federally recognized Tribal Nations engage in self-governance, either directly through the IHS or through Tribal organizations and intertribal consortia. In Fiscal Year (FY) 2020, approximately 50% of the IHS budget was distributed to self-governance Tribal Nations. However, despite the success of Tribal Nations in exercising these authorities under ISDEAA, the goals and potential of self-governance have not yet been fully realized. Many opportunities still remain to improve and expand self-governance, particularly within HHS. USET SPF, along with Tribal Nations and other regional and national organizations, has consistently advocated for all federal programs and dollars to be eligible for inclusion in self-governance compacts and contracts.

Attempts to expand self-governance compacting and contracting administratively have encountered barriers due to the limiting language under current law, as well as the misperceptions of federal officials. In 2013, the Self-Governance Tribal Federal Workgroup (SGTFW), established within the HHS, completed a study exploring the feasibility of expanding Tribal self-governance into HHS programs beyond those of IHS and concluded that the expansion of self-governance to non-IHS programs was feasible, but would require Congressional action. USET SPF maintains that if true expansion of self-governance is only possible through legislative action, Congress must prioritize this action. We strongly support legislative proposals that would create a demonstration project at HHS aimed at expanding ISDEAA authority to more programs within the Department. In addition, a major priority for Tribal Nations during the upcoming reauthorization of the Special Diabetes Program for Indians (SDPI), along with increased funding and permanency for the program, is ISDEAA authority. USET SPF looks forward to supporting legislation aimed at fulfilling these priorities during this Congress.

Improve Public Health Funding and Data Sharing

Many of the challenges and shortfalls plaguing the Indian Health Care System are the result of sustained, chronic underinvestment in prevention and public health measures paired with generations of historical trauma and structural discrimination. As the United States's public health infrastructure took shape and grew throughout the twentieth century, Tribal Nations were routinely left out of resource distribution. While Tribal Nations have always and continue to invest in the health and wellbeing of our citizens, our efforts continue to be hampered by lack of funding and inconsistently applied data sharing authorities. In order to more effectively respond to the challenges in our communities, including those posed by current and future public health crises, Tribal Nations need increased resources as well as the ability to efficiently and easily obtain necessary public health data.

In an already strained funding environment, there are often little resources left for public health prevention and surveillance activities in Tribal Nations. Although the IHS supports limited public health activities at federally operated facilities, the primary responsibility for the development and delivery of public health infrastructure and services often lies with Tribal Nations, particularly in regions with high concentrations of self-governance Tribal Nations. While many Tribal Nations and IHS regions have worked to incorporate some public health components in their governments, these entities often do not operate at the same capacity as state programs, and certainly lack much of the authority afforded to state entities. The Indian Health Care Improvement Act (IHCIA) authorized the formation of Tribal

Epidemiology Centers (TECs), and since 1996, the TECs have been working to improve the capacity of Tribal health departments to deal with public health issues and priorities. TECs are charged with seven main functions, including data collection, evaluation of systems, and the provision of technical assistance to Tribal Nations. The USET TEC, which serves Tribal Nations in the Nashville IHS Area, provides both aggregate and Tribal Nation-specific public health and mortality data in addition to its other functions. However, despite the critical nature of this invaluable work and Congressional directives to share data, TECs struggle with accessing public health data not only on the federal and state levels, but the Tribal levels as well. Access to timely, accurate data is vital to the delivery of healthcare services in Indian Country, as it is difficult to direct resources appropriately without fully understanding the challenges facing our people.

Congress has the obligation to correct these challenges within Indian Country. In addition to providing full funding to the IHS, Congress must meaningfully invest in public health capacity building in Indian Country. Funding for expanding the Community Health Aide Program (CHAP) to the lower 48 is one example of necessary investments in public health and preventative care in Tribal Nations. To mitigate challenges in data access, the federal government should compel agencies like the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) to issue specific guidance to states and other public health entities directing them to comply with legislative directives to share usable data with Tribal Nations. USET SPF is appreciative of efforts within the Subcommittee to conduct oversight in these matters.

Discussion Draft Recommendations

Clarification for Tribal Health Programs

While it appears that this bill is intended to apply to IHS-operated health care facilities only, we are concerned that potential unintended impacts to Tribal Nations operating facilities pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638 have not been adequately examined. ISDEAA is among the most successful federal Indian policies, as it recognizes our inherent Tribal sovereignty and self-determination by ensuring we—and not the federal government—are in the drivers-seat in addressing the needs of our communities. USET SPF member Tribal Nations operate in the Nashville Area of the Indian Health Service, which contains 36 IHS, Tribal, and urban health care facilities, of which 26 are Tribally-operated through contracts and compacts. Through exercising this self-governance authority under ISDEAA, USET SPF Tribal Nations have greater flexibility and control over federally funded programs to more efficiently and effectively utilize funding to meet the unique conditions within our Tribal communities. It is absolutely critical that the effects of this legislation on Tribally-operated programs are analyzed and consulted upon before it receives any further consideration.

Unfunded Mandates

Several provisions place additional administrative requirements on the IHS without providing additional resources for the agency to carry these out. USET SPF is concerned that in addition to creating compliance difficulties for the agency, these provisions will overtax the agency's existing administrative resources to the point of impacting other agency functions. It is unrealistic to expect that these new requirements can be successfully implemented in the absence of increased funding. As written, these new requirements will only exacerbate existing difficulties faced by the agency.

Section-by-Section Comments

Below, USET SPF offers section-by-section comments and concerns. Again, this bill should not move forward without additional, thorough Tribal Consultation on a national basis.

Section 101. Incentives for Recruitment and Retention.

In order to address the ongoing challenges with the recruitment and retention of IHS staff, the legislation would allow HHS to provide housing vouchers or reimburse the costs for those relocating to an area experiencing a high level of need for employment. Though this provision provides the Secretary discretion to determine whether a location is experiencing a high level of need, USET SPF suggests including language for positions that are "difficult to fill in the absence of an

incentive.” This addition would allow IHS more flexibility when determining when to offer relocation compensation.

USET SPF agrees that there is a need for recruitment and retention programs. However, the establishment of these programs should not come at the cost of health care services. USET SPF recommends that additional appropriations be authorized for the proposed recruitment and retention programs.

Additionally, it is unclear why the bill includes a sunset date on the housing voucher program. It is unlikely that IHS staff housing needs will be fully addressed in only a 3-year period. USET SPF suggests that the sunset date be stricken.

Section 102. Medical Credentialing System.

This section would create a uniform, standardized, and central credentialing system for the IHS to use in its hiring procedures. USET SPF has deep concerns about the centralization of any Area Office functions, including credentialing. Nashville Area Tribal Nations have consistently advocated for Area Office presence and for services to be administered at the Area level. Collectively, we have worked hard to establish the strong relationship we have with our Area Office today. Taking away functions from Area offices causes significant backlogs in services, and disrupts an established and trusted relationship between the Area Office and Tribal Nations. We believe credentialing should be kept at the Area level, utilizing established best practices. In addition, this provision serves as an example of the aforementioned unfunded mandates included in this bill.

Section 104. Clarification Regarding Eligibility for Indian Health Service Loan Repayment Program.

USET SPF encourages efforts that would expand the Indian Health Service Loan Repayment Program to include degrees in business administration, health administration, hospital administration, or public health professions as eligible for awards. We recommend including language that would expand these degrees as eligible under the IHS Scholarship Program as well. Allowing for comprehensive eligibility under these programs would increase the number of AI/AN individuals seeking business and health administration degrees, as well as increase the pool of qualified health professionals within Indian Country. In addition, we have long supported legislation that would confirm the nontaxable status of IHS student loan repayments in parity with other federal loan repayment programs.

Section 105. Improvements in Hiring Practices.

This section makes several changes to the IHS’s hiring authority that aim to give the Agency more ability to quickly address staffing shortages. First, it gives the IHS Direct-Hire Authority, which allows the Agency to bypass certain federal hiring procedures in order to appoint candidates directly to positions when there is a severe shortage of candidates or a critical hiring need.

On Waivers of Indian Preference, USET SPF firmly believes that the providers best suited to care for our communities are ones that come from the communities themselves. At the same time, there is room for improvements in hiring practices to ensure that positions are being filled in a timely manner with qualified candidates. We appreciate the inclusion of language to require Tribal requests to waive Indian Preference in order for the Agency to do so. However, we note that IHS included this policy change in its FY 2024 Budget Request in the absence of Tribal consultation or a provision requiring Tribal Nation approval. With this in mind, it is absolutely essential that this provision receive thorough Tribal consultation. Tribal Nations must guide its development and implementation to ensure that it accomplishes its aims without negatively impacting the development of a culturally competent workforce.

Section 106. Improved Authorities of Secretary to Improve Accountability of Senior Executives and Employees of the Indian Health Service.

While USET SPF understands the purposes of including language that would expand the Secretary’s authority to remove or demote IHS employees based on performance or misconduct, we believe Tribal governments must also be notified when IHS employees within their Service Area become subject to a personnel action such as removal, transfer or demotion. In addition, we ask that the Report to Congress describing the 1-year period following the enactment of this provision also be shared with Tribal Nations.

Section 107. Tribal Culture and History.

USET SPF has consistently supported additional training for all federal employees on the nature and history of U.S.-Tribal Nation relations, trust and treaty obligations, and respectful diplomacy with Tribal Nations. With this in mind, we support the inclusion of Section 107. However, because each Tribal Nation is a unique sovereign entity, language should be included that would require each IHS Area to design these trainings through consultation with the Tribal Nations they serve on a regional basis. This will allow the training to encompass regional cultural commonalities, as opposed to attempting to ascribe cultural similarities to Tribal Nations across the country.

Section 108. Staffing Demonstration Program.

This section would establish a demonstration project to provide staffing resources to individual clinics or service units. While we support efforts to increase staffing throughout the Indian Health System, our concerns with this provision are similar to those with Section 101. Financial resources are essential to the proper implementation to this provision. In addition, it remains unclear how the Agency would take just four years to make the program self-sustaining—especially without increased appropriations. Finally, the Agency appears to have outsize discretion in choosing sites for the demonstration.

Section 111. Enhancing Quality of Care in the Indian Health Service.

This section contains many provisions aiming to enhance the quality of care at IHS. While we appreciate Tribal consultation requirements and assurances that parts of this provision are optional for Tribally-operated facilities, we want to underscore the need to ensure that the diversity of Tribal Nations and Indian Country is reflected in the development of this provision. What may work for one Area and the Tribal Nations it serves may not work for another. In addition, any necessary resources should be extended to IHS in order to comply.

Section 112. Notification of Investigation Regarding Professional Conduct; Submission of Records.

This section requires the IHS to notify relevant Medical Boards no later than fourteen calendar days after starting an investigation into the professional conduct of a licensee at an IHS facility. This notification should also be extended to Tribal Nations served by that particular facility.

Section 113. Fitness of Health Care Providers.

Similarly, the reporting to Medical Boards under this provision must also be extended to Tribal Nations served.

Section 114. Standards to Improve Timeliness of Care.

This section requires IHS to establish standards that measure the timeliness of health care services provided in IHS facilities. It is imperative that any timeliness of care standards are developed in consultation with Tribal Nations and that this section confirms unequivocally that the standards do not apply to Tribally-operated facilities. In addition, we request that any data collected under the provision be provided to Tribal Nations as well as the Secretary.

Section 203. Fiscal Accountability.

USET SPF has concerns with this section and its effect on base funding. This section requires further technical evaluation and explanation, including from IHS, in order to assess its true impact.

Sections 302–304. Reports by the Secretary of HHS, Comptroller General, Inspector General.

USET SPF recommends including language that would require greater collaboration and consultation with Tribal Nations. We feel the reports laid out in this section should be conducted in collaboration with Tribal Nations and provided to those Tribal Nations for consultation prior to their release to Congress or the public.

Section 305. Transparency in CMS Surveys.

As above, USET SPF recommends adding language that would require collaboration and consultation with Tribal Nations during the formulation of these compliance surveys. We also believe the results of these surveys should be provided to Tribal Nations prior to their public release.

Conclusion

USET SPF acknowledges the efforts of the Committee and others within Congress in seeking to address the long-standing challenges within IHS. However, we believe that the discussion draft continues to fail to recognize the deep disparities in funding faced by IHS and how these disparities contribute to failures at the Area level. We maintain that until Congress fully funds the IHS, the Indian Health System will never be able to fully overcome its challenges and fulfill its trust obligations. Finally, a number of provisions within the bill seem to be responding to Area-specific concerns. While we stand with our brothers and sisters who are experiencing these failures, we ask that the Committee strongly consider the national (rather than regional) implications of the bill, and work with Tribal Nations to ensure its impact is positive in all IHS Areas. We thank the Committee for the opportunity to provide comments on this bill and look forward to further consultation The IHS Accountability Act, as well as an ongoing dialogue to address the complex challenges of health care delivery in Indian Country.

